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IN THE CIRCUIT COURT OF THE 11TH JUDICIAL CIRCUIT IN AND FOR DADE COUNTY, FLORIDA

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HOWARD A. ENGLE, M.D., et al.,
Plaintiffs,

-against-

Case No.
94-08273 CA 20

RJ REYNOLDS TOBACCO COMPANY, et al.,
Defendants.

----------x

January 27, 1998
9:35 a.m.

Deposition of ELIZABETH WHELAN, taken by Defendants, pursuant to Notice, at the offices of Dechert Price & Rhoads, Esqs., 30 Rockefeller Plaza, New York, New York, before Frank Bas, a Shorthand Reporter and Notary Public within and for the State of New York.

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IT IS STIPULATED AND AGREED by and between counsel for the respective parties hereto, that the within deposition may be signed before any Notary Public with the same force and effect as if signed and sworn to before the Court.

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ELIZABETH WHELAN, having been duly sworn by the Notary Public, was examined and testified as follows:

MR. ROSENBLATT: Before we get started, as I mentioned to the person that's going to be taking the deposition, who is Ned, that I just needed to say a couple of words.

It's our understanding that this was noticed to begin at 9:30, and it's about 9:35 now. We have eight hours for the deposition. We're willing to work through lunch, whatever you want to do, to move things along. But the deposition needs to be completed by approximately 5:32 p.m.

MR. DODDS: Well, we can agree to disagree about how much time we have, but let's start the examination.

EXAMINATION BY
MR. DODDS:

Q. Doctor, my name is Ned Dodds. I represent Philip Morris in this case, the Engle case. The request that I have is that if you don't understand what I am saying or a

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question is vague to you, please let me know and I'll try to rephrase it. And if you don't tell me there is a problem with the question, I'll assume that you've understood that.

Is that fair?

A. Yes.

Q. Dr. Whelan, would you please briefly describe for me your educational background?

A. I have a bachelor's degree from Connecticut College; a master's degree from the Yale School of Medicine in epidemiology in public health; a master's degree from the Harvard School of Public Health; and a doctoral degree, doctor of science from the Harvard School of Public Health.

Q. Since your time at Harvard have you had any further formal education?

A. No.

Q. Have you taken any courses of any kind since that time?

A. Not in the area that we're discussing here, no.

Q. In any other area?

A. I've taken cooking courses.

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Whelan

Q. You're currently employed, doctor?

A. Yes, I am.

Q. Where is that?

A. I am president and founder of the American Council on Science and Health, which is based here in New York City.

Q. How long have you been with the American Council?

A. I founded the organization 20 years ago.

Q. And you've been continuously employed since that time?

A. This is correct.

Q. At the American Council?

A. This is correct, yes.

Q. Doctor, you're not a medical doctor; is that correct?

A. Yes.

Q. As I understand it, you consider yourself primarily an expert in the area of public health?

A. Yes.

Q. And public health is different from basic medical research; is that right?

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A. It's complementary to basic research. Public health is a very broad field, covering a number of different disciplines, in preventive medicine.

Q. As I understand it, public health, as you practice it, is supplying data to others?

A. No, public health has a very broad mandate, including looking at the causes of disease, establishing various risk factors; looking at means of communicating health information to the public, and actually executing the communication process.

Q. And it's this execution of the communication process that you have largely devoted your career to; is that a fair statement?

A. It's a substantial portion of my career, but not exclusively, yes.

Q. I take it that you have not published any peer-reviewed articles in the field of epidemiology; is that right?

A. That's incorrect.

Q. What articles have you published in

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the area of epidemiology in a peer review journal?

A. I've published a number of different articles related to public health and epidemiology. Most recently an article on the relationship of lead and human health, which was just published last month in a peer review journal.

Q. And what journal is that?

A. I believe it's called the Journal of Ecotoxicology.

Q. What was the nature of the study?

A. The study was looking at the role, if any, of lead in the environment in the causation of human disease.

Q. What were your conclusions?

A. The conclusions were that, while there can be cases where lead can contribute to disease, particularly when lead is ingested in substantial amounts, that currently lead poisoning is not a very prominent and prevalent health concern in the United States today.

I would like to amend what I said. I

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actually have had two articles, and I've confused the sequence of them. Both in the same journal; one was on the alleged role of PCBs, polychlorinated biphenyls, in public health, and that's the one that was just published. The one on lead will be published next week.

Q. What was your conclusion with respect to PCBs?

A. That PCBs in trace levels in the environment do not pose a risk to human health.

Q. I take it that you don't agree with the EPA's assessment of the risk of PCBs?

A. I don't think the EPA would argue with our conclusions that at the levels they exist in the environment today, that they pose a known hazard to human health. They use the term "probable" or "possible" cause.

Q. If they don't pose a risk to human health, why is it that the EPA makes people like GE clean up areas like the Hudson River at a cost of many millions of dollars?

A. The EPA operates on what is known as

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the precautionary principle, which often mandates action even though there's no clear evidence of harm. My organization frequently disagrees with the Environmental Protection Agency on its mandates of that nature.

Q. Is there an organization or institution that sponsors the Journal of Ecotoxicology?

A. No, it's a peer review journal. It may be associated with an organization. I don't know the name of it, though. It's a peer review journal.

Q. Have you published any articles in a peer review journal with respect to issues of tobacco epidemiology?

A. I have published articles in peer review journals on the subject of tobacco, particularly, for example, I remember publishing one a number of years ago on evaluating how women's magazines report on the dangers of tobacco.

Q. Was that an epidemiologic study that you were reporting on there?

A. No, it was a study of the media.

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Whelan

Q. Have you taken any courses on the media, doctor?

A. I can't recall that I have. I may have. I have studied a lot of public health education at the various -- the two schools that I attended, and I may have had courses on the media. But I don't recollect them specifically.

Q. I understand you've taken one course in chronic disease epidemiology; is that correct?

A. I have taken many courses in epidemiology. It was over twenty-five years ago and I don't remember exactly the names of the courses or how many courses I had. I have been broadly educated in public health and epidemiology at Yale and Harvard.

Q. I understand, but limiting ourselves to chronic disease epidemiology, do you remember having taken more than one course in that particular field?

A. I don't recall taking specific courses with that title, no. But I know that my training involved the study of chronic as

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well as acute disease epidemiology. And I don't recall how many courses there were.

Q. As I understand it, you are now in the business of designing retrospect or prospective epidemiologic studies?

A. That is correct, that is not my business.

Q. And you have not designed a prospective study; is that correct?

A. I may have when I was in training as part of my education. I haven't recently, no.

Q. And you have not peer-reviewed a prospective study; is that right?

A. I've peer-reviewed many studies in my life for journals, and I don't recall whether any of them have been prospective.

Q. So sitting here today, you don't recall having peer-reviewed a prospective epidemiologic study?

A. No, I have not.

Q. I take it that statistical tests on associations are not your field of expertise?

A. I have, in my many courses in graduate school, studied biostatistics and

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statistical associations. I don't know what you mean by "expertise." I certainly have more expertise on that area than people walking around Rockefeller Center.

Q. Have you read any books on biostatistics in the last few years?

A. It's not part of my general reading in the last few years, no.

Q. You're not someone who independently reaches a conclusion about whether a given substance causes a given chronic disease; is that right?

A. No. As a matter of fact, I don't reach any independent conclusions, and haven't in the science area for the last 20 years. My views are those of a consensus, and the scientists associated with the American Council, which now totals over 250 scientists.

Q. As I understand your response to my question, you, yourself, don't independently reach these conclusions?

MR. HOAG: I object to the form of the question.

Q. You may answer.

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A. No, I do not. I reach conclusions in consensus with my colleagues.

Q. Since getting your degree at Harvard, Dr. Whelan, you have not been involved in any kind of academic research?

A. During the first five years when I graduated from Harvard, I was a research associate at the Harvard School of Public Health, and I was involved in the various forms of research there, particularly in the area of food safety and nutrition.

Q. And since that time have you carried out any academic research?

A. No, I have not.

Q. I take it that you, yourself, did not set criteria for determining whether a substance causes a chronic disease; is that right?

A. No. As I mentioned, I report on the consensus of scientists, not my individual assessments.

Q. You would agree with me that you're not an expert in legal matters?

A. I'm not an attorney, if that's what

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you mean.

Q. Would you agree that you're not an expert in the law?

A. I am not an expert in the law.

Q. And you're not an expert in psychiatry; is that right?

A. No, I'm not an expert in psychiatry.

Q. And you're not an expert in psychology; is that correct, doctor?

A. That's correct.

Q. You're not an expert in pharmacology; is that true?

A. I have some familiarity with pharmacology, and I don't know what you mean by "expert."

Q. Well --

A. Compared to what?

Q. Do you remember giving a deposition in the Allgood matter, Dr. Whelan?

A. Yes, I do.

Q. Do you recall having been asked the question:

"Question: Do you claim expertise in psychology?"

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And that your answer in that deposition was: "No."

Do you recall that?

A. I don't recall it, but I --

MR. HOAG: I'm going to object to this in that it's improper impeachment. And it's not impeachment at all, but you're using another deposition, you're not providing her with a copy of it. You appear to be trying to use it as an effort to -- for impeachment, and it's being used improperly.

To the extent you plan on using these numerous depositions where the doctor has been asked the same questions uncountable times, and wasting lots and lots of time here, I would ask that she be given an opportunity to see these depositions so that she makes sure she isn't being quoted out of context.

MR. DODDS: John, if you have an objection to the form of the question, that's fine. Anything else is inappropriate.

MR. HOAG: I'll make whatever objections I feel are appropriate. We'll let a judge decide whether they're appropriate or not.

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MR. DODDS: If you delay the deposition, we will have grounds to extend it to another day.

MR. HOAG: If you continue to ask questions that have been asked uncountable times when you already know the answer and misuse the attempt to impeach the witness with depositions in an inappropriate manner, I'll continue to make these objections.

MR. DODDS: You're not making an objection. You're making a speech.

Could you please read back the last question and answer?

MR. HOAG: And don't tell me what I'm making. I'm making an objection. Don't characterize what I'm saying.

MR. DODDS: We'll each make our record, John.

MR. HOAG: That's exactly correct.

(Record read.)

BY MR. DODDS:

Q. Let me ask you now, doctor, do you claim expertise in pharmacology?

A. I have some knowledge of

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pharmacology, and I don't know what "expertise" means.

Q. If someone were to ask you to appear as an expert witness in a matter involving pharmacology, do you think you would have the qualifications to do so?

A. It would be unlikely that I would accept such an invitation.

Q. Insofar as you know you don't intend to offer any opinions regarding pharmacology in this case; is that also true?

MR. HOAG: I'm going to object. She can't know every question that's going to be asked. That's up to the people that are asking her the questions.

Q. You may answer.

A. I don't know what questions you'll be asking me about pharmacology, particularly as they may relate to nicotine. And I would not want to exclude a comment about pharmacology of nicotine if indeed my organization has a consensus statement on it.

Q. Doctor, I'm going to show you your testimony in the matter of Allgood versus

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RJ Reynolds. Do you recall having given a deposition in that matter?

A. Yes, I do.

Q. Do you recall having been deposed under oath on Thursday, December 6, 1993?

A. I do.

Q. I direct your attention to page 103 of that deposition. You will note that there is a question: "Do you claim any expertise in the field of pharmacology?"

Do you see that?

A. I do.

Q. And what was your answer to that?

A. My answer then was: "No."

Q. Did you understand what the questioner meant by "expertise" at that time?

A. I think at the time I thought I did, but I've reflected on the question over the last five years and realized that I had to reevaluate what the term "expertise" meant and understand it better, if I were ever asked it again.

Q. All right. And since reflecting on it, do you now have an understanding of what

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the word "expertise" means?

A. Not fully, no.

Q. Do you use the word at all, doctor, in your daily work?

A. Yes, I do.

Q. When you use it, how do you use it?

A. I use it along the lines of my organization. I have access to many professionals with expertise in a variety of areas. And I think you can have an expertise in a general umbrella topic, which could include subdivisions.

For example, then, I could have some expertise about cigarette smoking that also includes some knowledge about pharmacology and the addictive nature of cigarettes. So I think it's a bit of an ambiguous question, and that's why I'm trying to answer it to the best of my ability.

MR. HOAG: For the record, the deposition you just showed her was a 306-page deposition taken in 1993. I don't know how many more you have, but we appreciate you showing her whatever statement you're referring to at the

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time you ask these questions.

Q. Well, let me ask you, doctor: If you had an issue of pharmacology in the course of your work, you would turn to one of the scientific advisers that you have on your organization, would you not?

A. I would turn to one of the pharmacologists in my organization if we did not have a previously declared consensus view on that subject already. Otherwise I would not turn to that person, because it would be part of my expertise.

Q. It's fair to say, doctor, you do not hold yourself out to the public as an expert in pharmacology?

A. That is correct.

Q. And you don't hold yourself out as an expert in toxicology; is that right?

A. I do not hold myself out as an expert, but I feel I have considerable knowledge and expertise also in toxicology.

Q. Have you any degrees in toxicology?

A. I do not.

Q. Have you taken any courses in

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toxicology?

A. Not that I recall, no.

Q. Do you have any toxicological texts in your office?

A. I do have toxicological texts.

Q. Which ones?

A. The texts that I have literally in my office is by Dr. Joseph Borzelleca, and I don't know the title of it but it's a text on the toxicology of pesticides, as I recall.

Q. Any others?

A. I may have others, but that's the one I recall.

Q. Do you hold yourself out as an expert in chemistry?

MR. HOAG: Objection to the form of the question. "Hold yourself" is vague, it's overbroad.

Q. You may answer.

A. I would not hold myself out as an expert in chemistry. However, in the last twenty years my work has focused very heavily on the area of chemistry, and I have some expertise in that area as a result of my work.

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Q. Would you agree, doctor, that you're not an expert in advertising?

A. I am not an expert in advertising. Again, though, when it comes to cigarette advertising, I've had considerable experience in evaluating cigarette advertising.

Q. Is it fair to say you haven't taken any courses in the area of advertising?

A. I have not.

Q. Or marketing?

A. I have not.

Q. Or in risk precision theory?

A. I have not.

Q. And you're not an expert in marketing; is that fair?

A. I have expertise in marketing of cigarettes because I've studied it for twenty years.

Q. Have you studied any other area of marketing?

A. Not to the extent I've studied cigarette marketing, no.

Q. Are you an expert in history, Dr. Whelan?

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A. I feel I am somewhat of an expert in the history of the cigarette in the United States.

Q. Would you regard yourself generally as an expert on historical matters?

A. No --

MR. HOAG: I object to the form of the question. "Generally on historical matters," it is so overbroad as to be unanswerable.

Q. You may answer.

A. I am not an historian.

Q. You're not an expert in medical history; is that true?

A. I feel I am somewhat of a medical -- an expert in the medical history of cigarettes in America.

Q. Let me direct your attention to page 104 of the transcript of your deposition in the Allgood matter, doctor, to the last question and answer.

Could you read the question and answer for me, please?

A. Question: Are you an expert in any subfield of medical history?

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"Answer: No."

Q. So your answer to that question was "no," is that fair?

MR. HOAG: I'm going to object to the use of the deposition. It's an improper attempt to do impeachment. There's no impeachment available based on her prior answers.

It's also a waste of time.

Q. Are you an expert on lobbying, Dr. Whelan?

A. No.

Q. You're not an expert in the political process as it relates to the passage of legislation; is that fair?

A. No. Yes, that's fair.

Q. You're not an expert in analyzing public opinion; is that true?

A. I've had some experience reading public opinion polls, but I do not hold myself out as an expert specifically on polling.

Q. Or in public opinion?

A. Correct.

Q. Are you an expert on public relations?

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A. I think I am, yes.

Q. By virtue of your experience at Council; is that correct?

A. That's correct.

Q. Have you ever received any training in public relations?

A. I can't think of any formal training, no. But I've had twenty years of public relations on-the-job training.

Q. Doctor, you're aware that there is a field of public relations; is that right?

MR. HOAG: I object to the form of the question.

A. I think the field of public relations is a very broad one.

Q. Right, I understand. And there are people who provide training to other individuals in the field of public relations? Have you ever taken such a course?

A. I don't know that such courses exist.

Q. I see, okay. Is there anyone on your staff who is responsible for press or public relations?

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A. Yes.

Q. And who is that?

A. I have a young lawyer working for me, his name is Jeffrey Stier, and he handles public relations and media for me.

Q. Do you also have an outside agent or public relations person?

A. Yes, I do.

Q. And who is that?

A. His name is Hugh Newton, N-E-W-T-O-N, and he runs Hugh Newton Associates, and it's a public affairs and public relations organization based in Washington, D.C.

Q. And what does Mr. Newton do for you or your council?

A. He assists in transmitting our message to the media, primarily print journalist, but also electronic media.

Q. How does he go about doing that?

A. In the traditional manners; through press releases, phone calls, arranging media interviews with me.

Q. And is he on retainer with your

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organization?

A. Yes, that is correct.

Q. I take it you also have a literary agent?

A. I don't at the moment have a literary agent.

Q. In the past you have?

A. I have, yes.

Q. Someone at William Morris?

A. That's correct.

Q. I take it you're also not an expert in pathology or cell biology; is that correct?

A. I am not.

Q. And you're not an expert in cigarette design? You're not an expert in cigarette design; is that right?

A. I'm not an expert in cigarette design, no.

Q. I think you mentioned before that you were the founder, or one of the founders for the American Council?

A. That's correct.

Q. Do you currently belong to any other professional organizations?

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A. Yes, I do.

Q. And what are they?

A. I would have to consult my resume. I can't remember where I'm current, but I have over the years been a member of the American Public Health Association, the American Institute of Nutrition, and other such organizations.

Q. Are there any advocacy groups that you are a member of or an officer or director of?

A. Advocacy groups?

MR. HOAG: I'm going to object to the form of the question in that the term "advocacy group" is vague and overbroad.

A. Do you mean, like, a political organization?

Q. Well, a political organization or an organization of scientists or others who are trying to espouse a viewpoint on matters of public interest.

A. Yes, I am a member. I'm involved in a number of organizations, all of which are not on the tip of my tongue. But I'm an

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officer, for example, of a political group here in New York City. I'm on the board of advisers of a political group here in New York City.

Q. What is that group?

A. It's called the East Side Conservative Club.

Q. Any other organizations?

A. Yes. I'm sure there are.

Q. But you don't recall them right now?

A. I believe I'm still an adviser of a group called Consumer Alert, which is a consumer activist group in Washington. I do tend to be involved in a number of different organizations.

Q. Would you agree with me that the American Council has had somewhat of a controversial life over the past twenty years?

MR. HOAG: I object to the form of the question; vague.

A. I will not agree with that until I understand what controversy would mean. No, I don't agree with that.

Q. Would you agree that individuals

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have criticized the American Council as a front organization for the food and chemical industries?

A. Yes. Some very poorly informed people who have no other better argument with me in public debate have made those unfounded charges.

Q. You are familiar with the Center for Science in the public interest reports?

A. Yes, I am.

Q. And they, a number of years ago, published a critique of your organization?

A. Yes.

Q. Entitled "Voodoo Science, Twisted Consumerism, the Golden Assurances of the American Council on Science and Health." Do you recall that?

A. I do.

Q. Did you put out a rebuttal to that piece?

A. I'll say yes, I'm sure we did. It was a very long time ago, but I'm quite sure we did.

Q. You and your organization have

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published a number of books and articles and press releases over the years?

A. That's correct.

Q. In fact, the Columbia Journalism Review, through its school, put out by the Columbia School of Journalism, printed an article entitled "Dr. Whelan's Media Operation"; do you recall that?

A. Oh, yes, I do.

Q. And among the things that it said is that "few opinion molders are as ubiquitous as Whelan."

And the role of molding public opinion, indeed, is part of what you regard as your mission; is that a fair statement?

MR. HOAG: I object to the form of the question. It's compound; it sounded like there were several questions in there.

A. I don't mold public opinion. I do not have that in my power. I do, however, provide information, particularly scientifically based information, which I hope people will absorb in making their own opinion.

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Q. A certain percentage of the American Council budget comes from corporations; is that true?

A. Correct.

Q. What approximately is the current percentage?

A. Approximately 40 to 45 percent.

Q. What are some of your largest contributors at the present time?

A. The three or four largest contributors -- there are very few large contributors. I think there are five of them. One would be Pfizer, Bristol-Myers, Johnson & Johnson, and American Home Products.

Q. Over the years you have stated on a number of occasions that these various corporate contributors do not influence your views or the views of your organization; is that correct?

A. That's largely correct, yes.

Q. And others have taken issue with that; is that also true?

A. A small number of people have taken issue with that, yes.

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Whelan

Q. Your feeling in general, however, is that it doesn't necessarily flow that receiving contributions from a corporation influences the quality or integrity of scientific research?

MR. HOAG: I object to the form of the question.

Q. Is that fair?

A. I don't consider that totally a reflection of my views. I think that corporate funding can very much be a source of influence on the positions of an organization, but not necessarily. But it certainly often is.

Q. It can and often is, but is it necessarily an influence?

A. I've always maintained that what is important in making that decision is not the funding but the actual veracity of statements the organization is making.

Q. In the past you have written articles suggesting that there was no such thing as an Agent Orange syndrome; is that correct?

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A. No, that isn't correct.

Q. You have indicated that you didn't feel that Vietnam veterans incurred injury as a result of their exposure to Agent Orange; is that correct?

A. That's quite different from saying there's no Agent Orange syndrome. There can be such a syndrome. My position on that is that the defoliant as used has never been causally linked with the illnesses claimed by Vietnam War veterans.

Q. Now, is it also the case that the American Council received funds from the makers of Agent Orange?

A. The maker of Agent Orange was Dow, from Midland, Michigan. Over the years we have received some modest funding from Dow.

Q. You've also written articles suggesting that the Gulf War syndrome is a phantom illness, is that also true?

A. No, that is not true.

Q. You've never characterized the Gulf War syndrome as a phantom illness?

A. What I've maintained is that

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veterans of the Persian Gulf who claim that some chemical exposure during their military service caused their current ailments has never been proven.

Q. You did write that it was the mother of all myths, did you not?

A. The mother of all myths, I was referring to the claim that their illness was related to their military service.

Q. Do you still believe that to be true?

A. Yes, I do.

Q. Is it also the case that some of the corporations who are defendants in lawsuits brought by Gulf War veterans are companies who have donated monies to your organization?

A. I'm not really totally familiar with the corporations that are involved in that. I think perhaps one of them, Zeneca ICI Americas could be one of the defendants. And they have modestly funded us. I am not aware of who the other ones are, so I can't answer that.

Q. Now, at least one instance the American Council submitted a legal brief in

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support of a position taken by one of your funders, Georgia-Pacific; is that correct?

A. We submitted a legal brief, I think it was an Amicus brief on behalf of -- I'm not sure it was on behalf of Georgia-Pacific. I don't recall on whose behalf it was. The topic was on the safety of formaldehyde. Other than that, I'm sorry, I don't recall who was the plaintiff or defendant in that. I don't remember that.

Q. Do you recall that your position was supportive of the position of the Georgia-Pacific Corporation?

A. Our position, always, was supportive of the scientific evidence, and only that.

Q. Do you recall there being a front-page article in the Washington Post that criticized your organization for not disclosing your involvement in that litigation was paid for by Georgia-Pacific?

A. I recall a front-page article in the Washington Post. We, at that time, published our funding list, and that litigation was not directly paid for. It was paid for out of our

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general operating budget.

Q. I've also read that you have recently proposed lowering the drinking age; is that correct?

A. In a Newsweek "My Turn" column, approximately two, maybe it was three years ago, I argued that perhaps teaching children to drink at home at an earlier age might take away some of the incentive to drink heavily at college, and I thought one way of doing that might be to lower the drinking age to 18.

Q. I take it you don't think parents should teach their children to smoke cigarettes?

A. I do not.

Q. You have also, in the past, submitted a legal brief in support of litigation against the tobacco companies?

A. I believe the American Council submitted an Amicus brief in the CiPollone case as it was being reheard before the Supreme Court. I cannot recall specifically anything more than that at this moment.

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Q. Do you recall that that brief was supported by Richard Daynard?

A. Yes, I do recall that Richard, Mr. Daynard, solicited the Amicus brief from the American Council, and we agreed to move ahead with him.

Q. And Mr. Daynard is a well-known anti-tobacco lawyer; is that a fair statement?

A. Yes, that's correct.

Q. So he was the one who suggested that your organization submit the Amicus brief?

A. That's correct.

Q. And he may have even written it; is that fair?

A. I would say that would be fair, yes.

Q. Is it fair to say that you have very strong feelings about smoking?

A. I have very strong feelings about smoking as a major cause of premature disease and death, yes.

Q. And you've referred to your work as a war against smoking?

A. It may be -- I may have, over the years, characterized it that way. I would

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rephrase it today as being that it is my -- my war is for improving public health and eliminating, as much as possible, factors that are obstacles to long life and good health.

Q. In fact, you've stated in the past, doctor, that you feel the industry is literally getting away with murder, haven't you?

A. I used that phrase in the subtitle of a book I wrote on the history of the cigarette.

Q. The answer is yes?

A. Yes.

Q. You also said in the same book that in your opinion cigarette manufacturers are actually no less guilty of seduction or rape than are molesters who tempt little girls with candy; did you not say that?

A. I would have to check my book, but if I have it in my book, then I did say it, yes.

MR. HOAG: If you have the book, we'll mark that as an exhibit and we'll stipulate to that.

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Q. In fact, the book you've referred to, the entire chapter is dedicated to how and why suits should be filed against the tobacco industry; do you recall that?

A. Yes. I wrote that book in the early 1980s, so...

Q. So you have a long history of those views; do you not?

A. I have a long history of those views because I think that litigation is a way of holding a corporation responsible for the consequence of its behavior, and that if indeed litigation is successful, it will provide the incentive for an industry to be more responsible and in this case in communicating the dangers of the product so that there can be a truly informed decision. I think that's the role, the very positive role that the threat of litigation poses.

Q. In fact, the name of the chapter was "Sue the Bastards," was it not?

A. Yes.

Q. I believe you were recently quoted as saying, "A feeding frenzy by the

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plaintiff's bar will force the tobacco industry to be more responsible"; do you recall that?

A. I don't recall that specific statement, but it's consistent with my view that the threat of litigation and ultimately some successful litigation will cause the industry to be more responsible.

Q. You've also indicated in the past, doctor, have you not, that cigarette smokers are frequently rude and thoughtless; do you recall having written that?

A. I do not recall having written that.

Q. Would you agree with it?

A. I would not make that statement today. I think the statement would be more appropriate for years ago.

Q. So smokers have become a little less rude and thoughtless in the past few years?

MR. HOAG: I object to the form of the question. Mischaracterizes her answer.

A. I certainly feel -- certainly recognize that smoking in public places is frowned upon, if not outright illegal. So the

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opportunities for smokers to be rude and discourteous, or whatever my terminology was back then, are not anywhere near as numerous.

Q. You've called in the past, at least, for a ban on advertising by cigarette companies; is that correct?

A. Many years ago I may have called for a ban on cigarette advertising. I have reflected further on that and find that that probably would not be a viable or a desirable bit of litigation to pursue. I think there are other means.

So I would not publicly take a stand now that we should ban advertising.

Q. We'll come back to that. Let me ask you, doctor, was it your view concerning the role of successful litigation against tobacco companies that prompted you to agree to be an expert witness in this case?

A. This is correct.

Q. When did you first have any communications with anyone at Mr. Rosenblatt's office regarding the possibility of acting as an expert witness?

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A. In this case specifically?

Q. Yes.

A. Perhaps two months ago. I don't recall the exact time frame, because I've talked to the Rosenblatts about a number of cases over the past year.

Q. You were initially contemplated as a possible witness in the Broin case; do you recall that?

A. I recall that I was considered to be one, yes.

Q. About when were you initially approached regarding that possibility?

A. I was approached as a possible expert witness for the Broin case perhaps six weeks before it went to trial.

Q. Did you have any conversations with anyone at that time?

A. I talked to Stanley Rosenblatt about the desirability or lack of desirability of me being an expert witness in that case.

Q. Do you know how he found you?

A. I do not.

Q. He called you up?

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A. He called me up a long time ago, and I don't recall when.

Q. And that was in regard to the Broin case?

A. I think perhaps the first time Mr. Rosenblatt called me was more of a generic discussion of cigarette litigation and the various avenues that he might pursue.

Q. Did you give him any advice in that regard?

DIR MR. HOAG: I would object. This is about the Broin case. She was not used as a witness in the Broin case. This is privileged information and I'm going to instruct her not to answer questions about the Broin case.

MR. DODDS: Do you care to lay any foundation?

MR. HOAG: No.

MR. DODDS: So any questions regarding any communication between the witness and anyone from your office, you would instruct this witness not to answer?

MR. HOAG: Regarding the Broin case. If you want to ask her about Engle, fine.

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Q. Do you know why, doctor, you were not called as a witness in the Broin case?

DIR MR. HOAG: Objection. This is privileged information. She wasn't a witness in the Broin case. I'm going to instruct her not to answer questions about the Broin case.

MR. CHUMBLEY: John, how is whether she knows --

MR. HOAG: You guys want to go to the judge on this, feel free. She's not going to answer questions about the Broin case. We're here on Engle.

MR. DODDS: I understand that, but we have asked many, many other witnesses regarding their involvement in the Broin case. This is the first time --

MR. HOAG: She wasn't called as a witness in the Broin case.

MR. DODDS: She was listed as a witness in the Broin case. She was retained as a witness in the Broin case. She was projected and a disclosure statement put in the public record regarding her contemplated testimony in the Broin case.

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MR. HOAG: It's a waste of time. If you want to ask her questions about Engle, go ahead. She's not going to answer questions about Broin.

Q. Have you had any discussions with Mr. Rosenblatt or someone from his office about any case other than Broin or Engle?

A. Not that I recall, no.

Q. I believe you indicated that your first conversation regarding the Engle case was several months ago?

A. Yes.

Q. Who spoke with you at that time?

A. I believe I was called by a paralegal from the firm and asked to testify, to offer -- if I could be listed for a deposition as a witness, as a potential witness.

There were no in-depth discussions at all.

Q. Was this during the fall some time?

A. Yes.

Q. Was that the first time that you understood yourself to be a possible expert in

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the Engle case?

A. That I was asked if I could be listed as a possible expert witness in the Engle case.

Q. Are you aware that expert disclosures have been filed in the Engle case regarding your possible testimony?

A. I believe that's why I was asked, my permission was asked regarding whether I could be listed, and I said yes.

Q. Were you provided any documents at that time?

A. No, I was not.

Q. Have you since that time?

A. No, I have not.

Q. Have you ever --

MR. HOAG: Well, other than the disclosure statement that we faxed you. I mean she has been provided the disclosure.

Q. When were you first provided with the disclosure statements?

A. The disclosure statement was faxed to me last week.

Q. And that was the first time you saw

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it?

A. The first time I saw it, yes.

MR. DODDS: Let me now mark as Exhibit 1 a disclosure statement, in pertinent part from the Engle case. The initial disclosure statement.

Q. I would ask you if you can identify it for me.

(Defendant's Exhibit 1, for identification, disclosure statement.)

Q. Doctor, is this one of the disclosure statements provided to you last week?

A. The document I'm referring to that I saw last week was more of an outline of the areas that I was to address in testimony.

MR. DODDS: Let me ask the reporter to kindly mark as Exhibit 2 a supplemental disclosure statement filed in the Engle case.

(Defendant's Exhibit 2, for identification, supplemental disclosure statement.)

Q. Looking at Exhibit 2, doctor, do you recognize it?

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A. Yes, I recognize it. "It" referring to the portion related to me?

Q. Right.

A. Yes.

Q. And that is the disclosure statement provided to you last week?

A. That's correct.

Q. And that was the first time that you saw Exhibit 2?

A. That's correct.

Q. Other than this document, doctor, have you been provided any other documents by Mr. Rosenblatt's firm?

A. No.

Q. Subsequent to your receipt of Exhibit 2, did you have a discussion with anyone from Mr. Rosenblatt's firm regarding Exhibit 2?

A. Yes. Last night I met briefly with Mr. Hoag to discuss this particular document and discussed the parameters of the deposition.

Q. And as best you recall, what did you tell him, if anything, regarding the expert

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disclosure?

A. I had discussed it very briefly by telephone with him. It seemed certainly fine with me the way it was written, and we didn't discuss it any further.

Q. Have you reviewed any documents to prepare for the deposition today?

A. I did read some of the chapters of the book I wrote on "A Smoking Gun" over the weekend, just to familiarize myself on the dates, the points in time. But other than that, I did not.

Q. And you read Exhibit 2?

A. I had already read that, yes.

Q. Did you receive any compensation, doctor, in connection with your work on the Broin case?

A. No.

Q. Why not?

A. I'm sorry, may I go back?

Q. Sure.

A. I did no work on the Broin case.

Q. I see, okay.

A. I received no compensation because I

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did no work.

Q. Are you going to be compensated for your work on the Engle case?

A. Yes.

Q. At what rate?

A. At $300 an hour while I'm in New York City; $350 if it's outside of New York, which is my standard fees.

Q. Let me ask you, doctor: You testified in a deposition in the Allgood case?

A. That's correct.

Q. And also in the Karbiwnyk case?

A. Yes.

Q. Have you given any other depositions in any other tobacco-related lawsuit?

A. Yes. I gave a deposition in December of 1997 over at Chadborne & Parke. I'm afraid I'm not going to be able to tell you the name of the defendant in the case, but I believe he's from the Midwest.

Q. That was upstairs?

A. That's correct.

Q. Other than those three cases, have you testified in any manner in any

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tobacco-related litigation?

A. Those are the only ones I can recall.

Q. Have you been retained in connection with any other tobacco-related cases, to your knowledge?

A. What does "retained" mean?

Q. Has someone hired you as a possible expert witness?

A. And paid me?

Q. Whether or not they have yet paid you.

A. No. I don't believe so, no.

Q. Do you contemplate that --

A. Excuse me. No, I have on my calendar a deposition in another case in Jacksonville, Florida. The word "retained" threw me, because I was not being paid by this particular attorney.

Q. You have not been?

A. No.

Q. Will you be?

A. No. Not that I -- I don't know. I have no idea. I haven't thought about it, in

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that case. I don't know the name of the case that I'm going to be deposed on, but it's mid-February.

Q. I see. Is there some reason you would be paid by Mr. Rosenblatt's firm and not be paid by another law firm, to your knowledge?

A. I just haven't given it a lot of thought, about what I was doing. But I may bill the other law firm as well. I just haven't -- we had not discussed it.

Q. Other than someone from Mr. Rosenblatt's office, have you discussed the Engle case with anyone else?

A. No.

Q. So I take it from your answer that you have not discussed this matter with any of the other witnesses designated by the plaintiffs?

A. No, I have not.

Q. So far as you know -- going back to Exhibit 2, Dr. Whelan -- does that state all of the subject matters that you will testify to at the trial of this matter?

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A. Yes, I believe it's a general outline of the areas that I would feel comfortable addressing.

Q. Are there any other subject matters, other than those listed, as to which you understand yourself to be proffered as an expert?

A. Not at this time, I don't know of any.

Q. Directing your attention, doctor, to Exhibit 2, the first subject matter is, relates to a consensus; do you see that, doctor?

A. I do.

Q. And Exhibit 2 states that, "Dr. Whelan is expected to testify that the consensus of the worldwide medical and scientific communities is that smoking causes cancer, including lung cancer, other cancers, emphysema, chronic obstructive pulmonary disease, heart disease, cardiovascular disease and other diseases."

Do you see that?

A. Yes.

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Q. What is your definition of the word "consensus"?

A. I would define "consensus" as in this case referring to the overwhelming majority of knowledgeable scientists and their views on a given subject.

Q. I'm sorry, when you say "in this case," is this a definition that you would apply in any context?

A. A consensus?

Q. Yes.

A. Yes. Overwhelming majority of opinion.

Q. Who decides whether there is a consensus?

A. A consensus is a judgment. I think it's very difficult for me to answer that out of context. If you wanted to ask me who would determine whether there is a consensus that cigarette smoking causes lung cancer, I think the consensus would be reflected in the peer-reviewed literature and the weight of the evidence. The weight of the evidence is overwhelming that scientists involved in

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studying the causal relationship of smoking and lung cancer, I think it can be stated that there is a consensus in that literature that such a causal relationship exists.

Q. Is consensus a medical or scientific term, in your judgment?

A. Consensus is a word in the English language.

Q. So to your knowledge there is no accepted definition in the medical or scientific community for the word "consensus"?

A. I think that those of us in the scientific community would accept the dictionary definition of the word consensus.

Q. There aren't any courses that one can take in how to go about determining whether there is a consensus; is that fair?

A. It's an English-language word that's defined in the dictionary.

Q. I understand, but my question is: The determination of consensus is not a field for scientific or medical exploration; is that correct?

MR. HOAG: Objection, asked and

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answered. She's answered this same question that you've reworded four or five times. I suggest you move on to another question.

Q. You may answer.

A. Consensus refers to the prevailing overwhelming view on a subject.

Q. I understand. My question is different, doctor. What I'm asking you is whether or not there is any training that one can have in determining whether or not a consensus exists?

MR. HOAG: Objection, asked and answered.

A. I have trouble answering that. Again, the training would be how to use the dictionary, read it and apply it to what the matter at hand is.

Q. So as far as you know, there are no professional societies that are devoted primarily to determining whether a consensus exists?

MR. HOAG: Objection, asked and answered.

Q. Is that correct?

MR. HOAG: This is about the fifth

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time you've asked the same question, slightly rewording it. Why don't you move on instead of wasting time.

Q. You may answer.

A. No.

Q. As far as you know, are there any published methodologies for determining whether a consensus exists?

A. I think this is not an understandable question. It's like asking are there medical societies that exist to help us understand the definition of a word. I don't know how to answer that.

Q. It's not a medical or scientific issue, I take it, from your answer?

A. A consensus in this case refers exclusively to medical issues. But the word "consensus" is not a medical term.

Q. Let me back up. You mentioned earlier today, doctor, that you regarded as part of your job to determine whether a consensus exists. And now I'm asking you whether there are any published methodologies that you're aware of that help you in that

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process.

MR. HOAG: I'm going to object. This has been asked and answered ad infinitum now. Why don't you move on instead of wasting time? Now you're just arguing with the witness and harassing the witness.

MR. DODDS: You're entitled to your view, John.

Q. Can you answer the question, please?

MR. HOAG: It's been asked and answered.

A. A consensus refers to the prevailing overwhelming opinion on a subject, and that is self-apparent.

Q. If it's self-apparent, doctor, then where does the judgment come in that you referred to before, when you said that consensus is a judgment?

MR. HOAG: Objection. This mischaracterizes her answer, and you're arguing with the witness.

A. I don't know where to go from here on it, other than repeating what I said.

Q. So you can't answer my question?

MR. HOAG: Objection, it's

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mischaracterizing her answer. She's answered your question over and over again, is what she's telling you, and you're just arguing with her now and harassing her.

Q. Let me try it a different way, doctor. You've stated before that whether a consensus exists is a judgment; is that correct?

A. It can be, but there can be an overwhelming consensus where there's not much judgment necessary. I mean, for example, whether there is a consensus of whether the earth is flat or not, I would say that there is a consensus, an overwhelming consensus that it is not.

So that's not a value judgment.

Q. Did you follow a particular methodology, Doctor, in reaching a conclusion with respect to the presence of a consensus along the lines set forth in Exhibit 2?

A. No, I used the definition in the dictionary in using that word to testify that there is an overwhelming majority view in the worldwide community. I would substitute those

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words with the word "consensus," and it would read just the same.

Q. What did you do, what methodology did you employ to determine whether there was an overwhelming majority view?

A. Over the course of twenty years I have read the literature and kept up-to-date on literature on smoking and, for example, lung cancer, and found that the overwhelming majority -- overwhelming majority of studies that looked at a causative relationship pointed to a positive association, or positive causal association. Therefore, since the overwhelming majority of these studies that I've reviewed and examined over the twenty years pointed to this conclusion, I reached there was a consensus.

Q. Doctor, has there always been a consensus with respect to the criteria which you determine whether or not a substance causes chronic disease?

MR. HOAG: I object to the form of the question. It's vague, it's overbroad.

A. Would you rephrase that, please?

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Q. Sure. The opinion that is set forth on Exhibit 2 talks about smoking causes disease.

A. Yes.

Q. And I take it by and large you are referring there to chronic disease; is that correct?

A. Not necessarily. Smoking causes acute diseases as well.

Q. Such as?

A. Such as immediate irritation and asthma are considered more of an acute impact of smoking rather than a chronic condition, like lung cancer.

Q. Do you know if pulmonologists would agree with your characterization of asthma?

MR. HOAG: I object to the form of the question. Do you have a particular pulmonologist in mind?

Q. You may answer.

A. I do not know of pulmonologists. I know there can be some acute effects associated with, acute being defined as an immediate, or near immediate.

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Q. By and large, doctor, when you're talking about disease here, you're speaking of chronic disease; isn't that true?

MR. HOAG: I object to the form of the question.

A. No, I'm not.

MR. HOAG: Let me finish the objection. Objection to the form of the question. Vague, overbroad; the words "by and large."

Q. Doctor, how many of the disease listed following the word "disease" are acute as opposed to chronic diseases?

A. These ones specifically mentioned are chronic diseases, but it does say other diseases at the end.

Q. So at least limiting ourselves for the moment to lung cancer and other cancers, emphysema, chronic obstructive pulmonary disease, heart disease and cardiovascular diseases, all of those are chronic diseases?

A. That's correct.

Q. My question to you, doctor, is whether or not there has always been a consensus, to your knowledge, in the medical

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and scientific community with respect to the criteria by which chronic -- the causation of chronic diseases is determined?

MR. HOAG: I object to the form of the question. It's overbroad.

A. So your question to me is not has there always been a consensus that cigarettes cause these diseases, but, rather, has there always been a consensus about the criteria to determine causality?

Q. Right.

A. I'm just having trouble understanding. Has there ever been a consensus about the criteria?

Okay. I would believe there has been, during this century, a group of parameters that have been widely embraced to the point of being consensus about the determinant, the important determinating factors in establishing causation. And these include looking for a strength of the association; looking to insure that the exposure preceded the disease in question; looking for repeatability confirmation in a variety of

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studies; looking for a biological hypothesis.

Criteria of that nature, I believe there is a consensus on the criteria for establishing causation.

Q. Doctor, is it fair to say that many scientists in the 1950's could not let go of traditional techniques which were employed to prove causation?

A. Scientists in the 1950's were really learning the relatively new science of epidemiology and were groping with how to relate the criteria for causation in infectious disease to ones in chronic disease. And that was a transition because, again, epidemiology was a relatively new science in terms of its broad application.

Q. O your answer is yes?

A. 'm sorry?

MR. HOAG: I'm going to object to your --

A. I can't answer just yes to some of these questions.

Q. Let me direct your attention, again, to the deposition in the Allgood matter.

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MR. HOAG: Again, this is the 1993 deposition taken, 306-page deposition taken in some other litigation.

Q. Let me direct your attention, doctor, to page 1261. In particular, the last question and answer. If you could read the question and answer, please.

A. Question: There are many scientists in the '50s who could not let go of traditional techniques which were employed, instead of doing acute infectious disease."

Q. That was actually the answer.

MR. HOAG: Well, it looks like that was the beginning of an answer, perhaps, and then it goes on -- there's another question perhaps prior to it, there is an ellipsis. I don't know, it's unclear. I don't know if she needs to read this in context and go over this deposition to give a complete answer or not.

But I object to the use of a small portion of one answer in some effort to impeach the witness, when she was interrupted by a question, at some point during this answer it's unclear whether or not she had

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more to say or not. And I don't know whether she can remember back that long ago.

Q. Let me ask you, doctor: Would you agree that it's fair to say that there was a debate in the scientific community in the 1950s on whether smoking was proven to cause lung cancer?

A. Yes, there was a debate. And I find that that question is totally in a different level, on a different subject than the one that you have been cross-examining me on, if you will, here.

Q. Yes, I understand.

A. And I see no conflict whatsoever between the deposition you just showed me and the answer I just gave. Other than the fact that in 1993, when I was pressed for yes or no answers, I tended to accept one or the other, and I think I am trying to be a little bit more sophisticated five years later.

Q. Would you agree, doctor, that some people use the term "cause" to mean biological mechanism?

MR. HOAG: I object to the form of the

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question. It's overbroad. "Some people"? It's vague and overbroad.

What period of time are you talking about?

MR. DODDS: Currently.

MR. HOAG: And which people are you talking about?

MR. DODDS: My question stands.

MR. HOAG: Well, it's vague and overbroad. Objection.

A. I can't answer the question, really, as it's posed. I would have to have it related to some specific topic. If you ask me are there some people who wish to use the word "cause" for lung cancer to relate to a biological entity, perhaps, but I can't answer that as broadly presented.

Q. You are aware that some scientists use the term "cause" in the context of determining whether smoking causes lung cancer as requiring proof of a biological mechanism; is that a fair statement?

MR. HOAG: Objection to the form of the question. Vague and overbroad.

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A. I don't know any persons who are schooled in the disciplines of epidemiology and public health who would require a presence of a biological mechanism to establish cause for a chronic disease.

Q. Has that always been the case?

A. As discussed during the 1950s, when epidemiology was a relatively new field for many people and many scientists, there were those who were making the transition between determining a biological agent as a cause, for example, with an infectious disease versus a chronic disease, where epidemiological evidence is sufficient to determine cause even without the presence of a known biological agent or mechanism.

Q. Would you agree, doctor, that there are biological hypotheses of how cigarettes may cause lung cancer, heart disease and other ailments, but the exact mechanism has not been fully spelled out?

A. I would agree with that.

Q. Would you also agree, doctor, that cancer is a complex multifactorial and

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multistage disease process?

MR. HOAG: I object to the form of the question. Overbroad.

A. I object to the nature of the question in the sense that cancer is so many different diseases, I couldn't possibly answer yes or no to that.

Q. Do you recall ever having made that statement?

A. In discussing of the process of carcinogenesis, perhaps.

MR. DODDS: I would ask the reporter to mark as the next exhibit an article by Dr. Whelan entitled "Cancer and the Environment: Facts Versus Fix."

(Defendant's Exhibit 3, for identification, article by Dr. Whelan entitled "Cancer and the Environment: Fact Versus Fix.")

(Recess.)

BY MR. DODDS:

Q. Dr. Whelan, can you identify Exhibit 3 for us, please?

A. It's an article with my byline. I

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can't really read where it's been published, Mining Congress Journal, which I've never really heard of, but it has my byline on it.

Q. Do you recall having written this article?

A. No. I do not dispute that I wrote it, though.

Q. You will agree with me, doctor, that on the first page of the article you state, "Cancer is a complex multifactorial and multistage disease process"?

A. That's what it says.

Q. In the right-hand column on the first page at the bottom of the first paragraph, the article also states: "The latency period, together with these other factors, makes the discovery of straightforward cause and effect relationships extremely difficult for all but the most potent carcinogens."

The article also says that, does it not, doctor?

A. Yes.

Q. On the sixth page of the article

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containing a large table, there is a heading "Analysis of Risk Factors Can Aid Understanding." Do you see that, doctor?

A. Yes.

Q. Let me direct your attention to the language under that where it states: "As understanding of the multifactorial nature of cancer increases, it becomes clear that precise etiological relationships are difficult or impossible to identify. And since the likelihood of contracting cancer is most often expressed in probabilistic terms, it is more useful to consider these relationships in terms of risk rather than cause."

That's what you said in this article; is that not true, doctor?

A. That's what this says.

MR. DODDS: Let me ask the reporter to mark as the next exhibit, Defendant's Exhibit 4, a multipage document from the American Council on Science and Health entitled "Cancer in the United States: Is There an Epidemic?"

(Defendant's Exhibit 4, for

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identification, multipage document from the American Council on Science and Health entitled "Cancer in the United States: Is There an Epidemic?".)

Q. Doctor, directing your attention now to Exhibit 4, do you recognize this document?

A. I recognize it as a 20-year-old document published by my organization.

Q. This is a position paper put out by your organization?

A. Yes, twenty years ago.

Q. Directing your attention to page 6, at the bottom of the right-hand column you stated at that time: "In asking the question what causes human cancer, it is more meaningful and technically correct to consider the concept of risk rather than cause, since it is becoming increasingly clear that cancer is a result of complex interaction of causative agents, both environmental and genetic."

That's what you stated in your organization's position paper, did you not?

A. Yes.

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Q. Would you agree, then, doctor, that epidemiology can identify association between different variables but not cause and effect?

A. I think this -- no, I wouldn't agree with that. And I think this becomes largely a semantic issue. I believe that twenty years ago my vocabulary -- the vocabulary of the American Council -- was overly cautious. We were writing as if we were presenting in a seminar at the Harvard School of Public Health, in making distinctions between risk and cause.

There comes a point, and surely we have reached that point, for the relationship of smoking and lung cancer, that smoking has been -- is certainly a risk factor, but it is such a risk factor, it can be, in layman's language as well as professional assessment, called a cause of lung cancer.

Q. Well, my question, doctor, is whether or not you would agree with the statement that epidemiology can identify association between different variables but not cause and effect?

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A. No, I would not agree with that.

Q. You recall, do you not, giving a deposition in the Allgood case, doctor?

A. I recall giving a deposition, yes.

Q. Let me direct your attention to page 92 of your deposition, and let me ask you to read the first question and your answer indicated on page 92.

A. Starting at the top?

Q. Starting with line 6.

A. "Question: Isn't it true that epidemiology can identify association between different variables but not a cause and effect?"

Q. And what was your answer?

A. "Answer: This is true."

Q. Has your view then changed between 1993 and 1998?

A. Yes. I would use stronger language and use more synonymously -- when risk factors are as strong as they are with smoking and lung cancer, I would use more synonymously risk factor and cause than I did then.

Q. In 1993, doctor, how long had you

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been in the field of public health?

A. At that point about twenty years.

Q. What caused you to have an epiphany in 1993 or thereafter with respect to the issue of risk versus cause?

A. It wasn't an epiphany. It was simply a matter of semantics. Back then, as I do now believe, again, that obviously epidemiology starts by looking at risk factors. But there comes a point where a risk factor is so significant that it can be elevated to the terminology "cause." And that's the case in many aspects of cigarettes and disease.

Q. You have made the statement, have you not, doctor, that when you deal with chronic diseases, causation is really referring to increased risks?

A. Yes, that is correct.

Q. And you would also say that it's a very difficult thing to prove the causation for a potential carcinogens, since a long period of time may pass between the exposure and the development of the disease?

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A. All these things are correct. And I stand by my statement that this is a semantic discussion only in that if I were giving a seminar at the Harvard School of Public Health, I would refer to cigarette smoking as a risk factor, and everyone would know what I meant.

Q. Doctor, you wrote a book entitled "The Complete Guide to Preventing Cancer"; do you recall that?

A. Yes.

Q. Published in 1994?

A. Yes.

Q. And this was the updated and revised version of an earlier work?

A. That's correct.

Q. Do you recall stating in this book: "Causation is a very difficult thing to prove for potential carcinogens, since long periods of time may pass between exposure and development of the disease, so instead of trying to prove something causes cancer, in the traditional sense of the word 'cause,' scientists attempt to demonstrate that

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exposure to substances or life-style factors increase the likelihood of getting cancer."

Do you recall saying that in that book?

A. I don't, but if it's in my book, I said it.

Q. Does this remain your view today?

A. I would stand by that statement. Again, I maintain that the difference between established risk factor and cause is a semantic one, and one that is not of any critical importance at all.

Q. You would agree with me that in the technical sense we don't use the words "smoking causes cancer" together?

MR. HOAG: I object to the form of the question.

A. I am a public health professional and regularly use the phrase "smoking causes cancer." I have no trouble with that. Though smoking is a risk factor, a major -- the major risk factor, to the point of elevating it to cause. And that's the terminology that I use.

Q. But when we say cigarette smoking

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causes lung cancer, doctor, that is really a shortcut, isn't it?

MR. HOAG: I object to the form of the question, "when we say."

A. I wouldn't call it a shortcut. I would say it's a more understandable lay language term. It's the bottom-line term.

Q. Doctor, let me direct your attention to your testimony in the Allgood case, page 553, line 19 through 21, and ask you if you could read the question and your answer into the record.

A. On page what?

Q. 553.

A. Starting at the top?

Q. I believe it's from line -- I'm having a hard time reading upside down. You were asked the question, doctor:

"Question: When we say cigarette smoking causes lung cancer, that's really a shortcut?"

What was your answer?

A. "That's correct."

MR. HOAG: One thing. Can I see it again

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for a second?

MR. DODDS: Let me continue with my examination.

MR. HOAG: Just for the record, I misspoke when I said it was a 306-page deposition. Obviously the deposition from 1993 was over 500 pages. I don't know how many over 500 pages. It looks like it took two full days, I guess. We weren't present for that. It was in a different case.

Again, for the record, these are small portions of an over 500-page deposition being quoted briefly, selectively, by the only person here who has a complete copy of the deposition to look at.

So to that extent I would object to its use for this deposition. The witness is here to answer questions today about Engle and her knowledge. And that's all I have to say about that deposition at this point.

How many pages is it exactly, Ned? Is it 590?

MR. DODDS: If I could continue with the examination.

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Q. Let me direct your attention to the same page. You were asked the question:

"Question: What we are really saying is that is cigarettes a risk factor for lung cancer?"

Do you see that question on the same page?

A. Yes.

Q. And what was your answer?

A. "Yes." And I agree with that today, cigarettes are a risk factor for lung cancer.

MR. HOAG: And I'm going to object again to the use of a five-year-old deposition that looks like it's 600 pages or more long, to try to use for impeachment when, in fact, you're asking questions that she has already agreed to. For example, that one.

She explained that she uses the term sometimes synonymously. So you're using an old deposition for an improper purpose and wasting a lot of time.

MR. CHUMBLEY: You are, John.

MR. DODDS: John, you're wasting time by making speeches.

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Q. Let me ask you, doctor, you also testified in the Allgood case, you were asked the question:

"Question: But under traditional concepts of causation, we don't say that smoking causes cancer; is that right?"

What was your answer?

MR. HOAG: I'm going to object again to the use of this deposition rather than just ask her questions. You're asking "we don't say" -- I would object to the use of this, because the "we" is -- I would object on form to this question. The fact that the attorney there didn't object to the form of these questions is unfair again to the purposes of this deposition.

This is an old deposition. You're quoting it out of context and you're misusing it. This isn't impeachment.

MR. DODDS: Could you re-read my question, please? Let me strike that.

Q. You were asked under oath in the Allgood deposition the following question, doctor:

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"Question: But under traditional concepts of causation, we don't say that smoking causes lung cancer; is that right?"

What was your answer?

MR. HOAG: This is page 553 -- 554, at lines 11 through 13, of the deposition taken on December 17, 1993, for which we were not present. Go ahead. Just for the record.

Q. What was your answer?

A. My answer was:

"Question: Is that right?"

"Answer: In the technical sense we don't use those words together, no."

Yes, and I believe that's consistent with what I've stated here today.

MR. HOAG: Again, improper use of deposition for purposes of trying to impeach the witness when, in fact, it's not impeachable at all.

Q. Let me ask you: Are you aware that a number of the tobacco companies also state

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that cigarettes are a risk factor for the development of lung cancer?

A. I have heard that of recent date. It's a relatively recent phenomenon. Yes, I am aware of that.

Can I elaborate on that answer?

MR. HOAG: Yes, you can.

Q. If it's responsive, sure.

A. I am aware that tobacco executives use the term risk factor, but what they fail to address is the critical factor. There are risk factors and then there are very strong risk factors.

For breast cancer, for instance, the age at a first birth is a risk factor for breast cancer. A woman who has a child, a first child rather late in life, has a higher risk of breast cancer. I would never use the term "cause," that delayed child bearing is a cause of breast cancer. It is a risk factor.

Contrast that to cigarette smoking is a risk factor that is so significant, it can be termed a cause, unlike the other example I gave.

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And the industry that you referred to uses the term risk factors as if it were something very insignificant.

MO MR. CHUMBLEY: Move to strike as unresponsive.

MR. DODDS: I will join.

Q. Doctor, let me go back to the question of consensus. Do you have Exhibit 2 in front of you?

A. Yes.

Q. Could you tell us, please, when the consensus arose with respect to these various diseases that are mentioned in Exhibit 2?

A. My statement here was regarding the consensus that exists today. In terms of when a consensus, as defined as the overwhelming majority, I would have to separate out these particular chronic ailments. And I would give you just ballpark times.

When was there a consensus that cigarette smoking caused lung cancer? I would say that there was a consensus by the late 1950s, if not earlier.

In terms of coronary heart disease,

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perhaps the consensus that cigarette smoking was a preventable cause of heart disease, I would suggest that consensus perhaps was somewhat later, maybe in the '60s, in the early '60s.

Q. And what about COPD?

A. Again, I would say that for chronic obstructive pulmonary disease, that the consensus was reached also perhaps in the mid-1960s, if not before.

Q. You would agree with me that there was a debate going on in the '50s as to whether smoking caused lung cancer?

MR. HOAG: I'm going to object to the form of the question. It's vague, overbroad.

A. I would answer that question that yes, there is a debate. But I could also say there was a debate going on in 1998. If you have a million people saying one thing and one person saying another thing, that's still a debate.

Q. You believe there was a consensus by the late 1950s?

A. I believe that there was a consensus

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that cigarette smoking caused lung cancer by the late 1950s. Because by 1957 there were consensus statements being made.

As I recall, that was the year the United States Public Health Service issued a statement on smoking and lung cancer.

Q. Doctor, do you recall being asked the question in the Allgood deposition:

"Question: Have you done anything to determine whether there was a consensus in the 1950s in the scientific community, whether smoking was a cause of cancer?"

MR. HOAG: I object to the form of the question. It's also improper impeachment.

A. I don't recall that.

Q. Let me direct your attention, then, to page 562 of your deposition in that matter.

MR. HOAG: What line are you on?

Q. At the bottom of the page.

MR. HOAG: What line are you on?

Q. Line 17.

A. "Question: Have you done anything to determine whether there was a consensus in the 1950s, in the scientific

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community, whether smoking was a cause of cancer" --

MR. HOAG: You're just reading a question.

Q. What was your answer?

MR. HOAG: Just for the record, so we know for the record, she was reading a question that was asked in another deposition on page 562 back in 1993.

A. "I have reviewed the literature and I would say that there was not a consensus because there was great resistance even in the scientific community to accepting the emerging data."

I believe that I would stand by this answer, and also what I just stated, because this refers to the 1950s as a decade, and I was referring to 1957 as the date of the, one of the consensus statements that I offered as an example.

MR. HOAG: Again, for the record, it's improper attempt to use this for impeachment, and again, it is a waste of time.

MR. DODDS: I would ask the reporter to

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mark as the next exhibit an article from New York Newsday, January 11, 1994, entitled "Get Rid of the Cigarette Warning Label," by Elizabeth M. Whelan. That will be Exhibit 5.

(Defendant's Exhibit 5, for identification, article from New York Newsday, January 11, 1994, entitled "Get Rid of the Cigarette Warning Label," by Elizabeth M. Whelan.)

Q. Doctor, directing your attention to the paragraph entitled -- I'm sorry, that starts, "During the mid-1960s." Do you see that paragraph?

A. Yes.

Q. The paragraph states, "During the mid-1960s, when the hazards of smoking became undeniable to policy makers, nearly 30 years after the scientific community had reached consensus on the issue, public health activists and the tobacco industry both lobbied Congress for warning labels."

A period nearly 30 years prior to the mid-1960s would be the late 1930s, would it not?

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A. That's correct.

Q. So what you were saying in this article you wrote is that the scientific community have reached consensus on the issue in the late 1930s?

MR. HOAG: I object.

Q. Is that correct?

MR. HOAG: This is a mischaracterization of her prior testimony. This statement uses the words "hazards." Your question and her answer were specifically relating to cancer.

Q. You may answer.

A. I'm undecided about whether this was actually -- actually, A, could have been a typographical error. What I meant to say, ten years after the scientific community; or, on the other hand, I do refer to the hazards of smoking, and surely by the late '30s it was very well known that cigarettes harmed health, though we certainly did not have a consensus about it causing lung cancer. I'm uncertain at the time that this was written exactly which of those two would explain it.

But I would repeat, I would not

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maintain that there was a consensus on cigarettes causing lung cancer or other chronic diseases in the late 1930s, though there was a consensus then among physicians that cigarettes were hazardous to health. They were certainly not promoting good health.

Q. There was a consensus about the hazards of smoking in the late 1930s, Doctor?

A. I believe there was. It was considered causing coughs and respiratory distress, yes. Doctors knew that cigarettes were not promoting good health, and yet they did not know about the very serious life shortening effects of cigarettes. As I've said, I remain ambivalent about which of those two explanations would be appropriate for this article.

Q. You would agree with me, doctor, that the article states that in the mid-1960s the hazards of smoking have been a matter of consensus among the scientific community for nearly 30 years?

MR. HOAG: Objection. It's been asked and answered. You're just now harassing the

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witness. You don't like her prior answer so you're trying to harass her by asking her the same thing three different times.

Q. You may answer.

A. I think I would be repeating myself again. I would not stand by that 30 years prior to the mid-1960s there was a consensus in the scientific community that cigarettes caused lung cancer. That would be false.

However, there was a consensus that it was incompatible with good health. No one had any concept of -- very few people -- I'm sorry, not no one -- very few people had a concept of how serious an effect it was having.

Q. So you would agree that it was not the prevailing view in 1938 that there was a risk of lung cancer associated with cigarette smoking?

MR. HOAG: Objection, asked and answered.

A. Prevailing view among whom?

Q. Among scientists and medical researchers.

A. I would say it was not a prevailing

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view among the aggregate of scientific researchers, no.

Q. Doctor, do you consider yourself to be in a position to testify one way or the other about what the prevailing view was in the '30s or '40s or '50s, or even the early '60s?

MR. HOAG: I object to the form of the question. She's answered questions about what her areas of expertise are. To the extent you're asking her the same question again, it's repetitive.

A. I am prepared to offer testimony about what the peer-reviewed scientific literature reported on the dangers of smoking during the '30s, during the '40s and during the '50s.

In terms of what the prevailing view was, the question would be, A, among whom?

And, B, how would that -- how that would be measured.

And it is my feeling that what is available in the scientific literature, raising serious suspicions and confirming

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those suspicions about the dangers of the product, was enough that should have prompted the manufacturer of that product to communicate that information, even if it were considered tenuous to potential consumers.

Q. Doctor, did I ask you about whether something should prompt the tobacco companies to do something?

MR. HOAG: I object to the form of the question. You are merely arguing with the witness. She answered the question to the best of her ability. You don't need to argue with her about what you asked her.

MR. DODDS: I'm not doing any arguing.

MR. HOAG: You certainly sound like it. Even though your tone of voice is low, you're arguing with the witness. You don't need to yell sometimes to argue with the witness, Ned. You know that.

MR. DODDS: I don't mean to be argumentative.

Q. Doctor, you gave a deposition in the Karbiwnyk case; do you recall that?

A. Yes.

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Q. And that was several months ago, in September?

A. Yes.

Q. Specifically you were deposed on several days, but including September 26, 1997; correct?

A. Correct.

Q. And you were under oath at that time?

A. Yes.

Q. Do you recall being asked this:

"Question: In the scientific community in 1950, would it have been the prevailing view that the studies you're referring to established the cause and effect relation?"

MR. HOAG: Objection.

Q. Do you recall --

MR. HOAG: First objection. This is improper attempt to use impeachment.

MR. DODDS: Can I finish my question?

MR. HOAG: She has a right to see this. Again, you're using this for an improper purpose.

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MR. DODDS: Your objection is on the record. Thank you.

MR. HOAG: And your waste of time is on the record. Continually.

Q. Doctor, let me ask you: Do you recall having been asked that question, which appears at line 14 of page 170 of the transcript of your deposition in the Karbiwnyk matter?

A. Again, we're talking about the --

MR. HOAG: Let her finish the answer.

MR. CHUMBLEY: Let her answer the question first.

MR. HOAG: Let her finish her answer.

Go ahead, you can say, again, you were talking about what?

A. You asked me if I did say this, and it's on the record, so I said it. And what I was referring to was the entire decade of the 1950s, which really has to be separated out into the early, mid-, and late '50s.

MR. HOAG: Again, my objection on the record. You're just trying to confuse the witness.

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MR. DODDS: I haven't finished my question.

MR. HOAG: She's answered this about the '50s versus 1957; she's explained it, and you're trying to use out-of-context words from prior depositions that took hundreds of pages to confuse the witness. And when she tries to clarify it, you try to interrupt her.

MR. DODDS: Well, I don't think I have, John. And I have more confidence that this witness is not easily confused.

Q. Doctor, did you not state at that time that you could not say what the prevailing view was in 1950 or, as you put it, throughout the 1950s, because you were not there?

MR. HOAG: Objection.

Q. Didn't you say that?

MR. HOAG: Objection to the form of the question. "Did you not state"? It's a very confusingly worded question. I have no idea what you want to know.

And if you want to show her what you're referring to, again, you can do that.

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MR. CHUMBLEY: John, please stop the speaking objection, please. You know that's improper under the rules.

MR. HOAG: No, this is not improper. What's improper is the methodology of questioning her. That's what improper here.

Q. You may answer.

MR. HOAG: And I'm objecting again.

MR. CHUMBLEY: We know, we heard you.

MR. HOAG: Good, I'm glad you heard me. You're going to keep hearing me if this keeps up.

Q. Can you answer the question?

A. Did I and do I know what the prevailing view of the '50s is?

Q. Let me rephrase the question. You've indicated that you're not in a position to state what the prevailing view was during that time because you weren't there?

MR. HOAG: Objection.

Q. Isn't that true?

MR. HOAG: It mischaracterizes what she said. She said back in the early '50s versus 1957, is what she was referring to, as far as

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consensus is concerned. She's answered this question already.

MR. DODDS: John, I really object to your speaking objections and instructing the witness. I'm not trying to confuse her. I'm asking her to answer a straightforward question.

Would you please read the question back?

(Record read.)

A. I'm not -- I am not and was not in a position to state the prevailing view for the entire decade of the 1950s because I wasn't there and was not part of it.

On the other hand, I am in a position to report that the prevailing view reported in a consensus meeting in 1957 was that smoking caused lung cancer.

MR. DODDS: Read that back for me?

(Record read.)

MR. HOAG: Which is exactly what she said three or four answers ago, or more.

Q. Would you agree with me that it's possible that people reading the literature

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then, including that consensus document, did not see them as proof of a cause and effect relationship?
MR. HOAG: I object to the form of the question. Vague and overbroad, "Is it possible that."
MR. CHUMBLEY: Just object to the form, okay? If we want a reason, we'll ask you for one.
MR. HOAG: Well, I'll give one if I feel like it. I'm trying to move this along so we ask questions that make some sense. "Is it possible that?" It's a great question.
MR. CHUMBLEY: It will be answered.
A. It is possible that anything could happen; that anyone could imagine anything and say anything.
Q. Well, you were not a part of the scientific community at that time; is that correct?
A. That's correct.
Q. And so to that extent you're not in a position to know what was in the minds of the people in the community at that time; is
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that not also correct?

MR. HOAG: Objection, asked and answered.

A. What is important is not what is in the minds of these so-called undefined people. What is important is what was in the peer review, the literature, which is a state of knowledge at the time, and that I am aware of.

Q. So in your judgment, Dr. Whelan, consensus can be determined solely by reference to published literature?

MR. HOAG: Objection, mischaracterizes the testimony.

A. No. As I mentioned, consensus emerges when there is, for example, a meeting of organizations that look at the totality of the data at that point, which is what happened with the U.S. Public Health Service in 1957.

And I feel uncomfortable answering questions about consensus constantly, because it seems to me, by answering them, I am buying into a premise with which I do not agree. And that premise seems to be that one must have consensus before there is action on a public health

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matter.

Q. I'm going to ask you to turn back to Exhibit 2, your statement.

A. Yes.

Q. Exhibit 2 indicates that you will testify as to the history of the tobacco industry and the fraud that has been perpetrated on the public, including local, state and national governmental authorities and agencies, including "a frank statement" in 1954.

Is it your intention, Dr. Whelan, to testify on this subject?

A. Yes.

Q. Can you please tell me, as best you can, what your views are on this subject?

A. In summary, my views are that starting in the early 1950s, when prospective ongoing studies reported in the medical literature showed, in a new epidemiological form, namely not just retrospect of observation but in following people for long periods of time, when those studies showed that smoking was a major risk factor, a cause,

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if you will, for lung cancer, the tobacco industry and its various surrogates made a conscious decision to deny those particular findings, to confuse people about those findings, to claim they were doing more research without acknowledging the legitimacy of the research that already existed.

They made attempts, direct or indirect, to keep the -- to inhibit the free flow of information on the dangers of smoking in magazines, particularly magazines, and they created their own forms of media to publicize the views of those who claimed that the emerging research was flawed.

In summary, I will be testifying to the fact that the industry and its surrogates, including the Tobacco Institute, were involved in a campaign of misinformation and disinformation about the effects of smoking on health, instead of sharing with the public the growing amount of information indicating that smoking was hazardous to health in many forms.

Q. Your disclosure statement uses the word "fraud," Dr. Whelan. What definition for

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fraud do you use?

A. I would use the definition of a non-lawyer. To me fraud would be misrepresentation of information. And in this case I would see fraud in the sense that cigarettes were being marketed and advertized without a disclosure of existing evidence on their hazards.

Further -- that would be the disinformation, the failure to provide full disclosure.

But further to that, I think laymans use the word fraud involved in providing misinformation, claiming that studies were invalid. Proposing other unproven speculation about causes of lung cancer, for example.

Q. Do you know what the definition of fraud is under Florida law, doctor?

A. No, I do not know. I do not know Florida law.

Q. Can you tell us, please, what documents you intend to rely on, or refer to, in the course of your testimony on this subject, if any?

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A. I don't know that I'll rely on any documents. I have been observing the tobacco industry for over twenty years, and I have spent considerable time reading popular media coverage, press accounts, magazine coverage during the '40s, '50s, '60s and beyond.

I've read tobacco industry publications, including the "Tobacco Observer" and "Smoking and Health."

Statements by the tobacco industry. Advertisements placed by the industry, starting with the frank statement in 1954.

And my testimony would be based on my absorbed knowledge of all those reading and exposure.

Q. Can you tell us what specific fraudulent statements you are referring to in this paragraph, if any?

A. Well, starting with the frank statement, my definition of fraudulent would be that it was inconsistent with the information available in the literature at that time, in 1954.

The frank statement was a full-page

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newspaper ad placed by the tobacco industry, basically denying that there was any evidence about smoking being causatively linked with lung cancer.

And misrepresenting the state of knowledge at the time.

I made a statement in my book, I think it was January 4, 1954, or whatever the date in January was, the day that the tobacco industry officially became dishonest.

Q. Now, the frank statement was in 1954; is that correct?

A. January 1954.

Q. And the consensus that you have testified to earlier with respect to lung cancer did not develop until 1957; is that correct?

A. What I said was that the first that I'm aware of consensus meeting, the United States Public Health Service, took place in 1957. But again, the question again has me buying into a premise I do not believe.

I don't believe that in 1954 there needed to be such a consensus meeting on

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record to make the frank statement misleading, and in my lay terms, a fraudulent representation of the facts that existed in 1954, with or without so-called consensus.

MO MR. DODDS: I would move to strike that response as non-responsive.

MR. HOAG: It's perfectly responsive.

MR. HRANITZKY: I'll join.

Q. My question to you, doctor, is that the consensus statement that you referred to before first appeared in 1957; is that correct?

A. Correct. The first one I'm aware of.

Q. Is a consensus statement the same as a consensus, in your view?

A. A consensus statement reflects that there is a consensus.

Q. Let me ask you, Dr. Whelan: Do you know of a single person who was misled into believing the wrong thing because of something one of the defendants in this case said?

A. I do not, as an epidemiologist public health expert, deal with individuals; I

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deal with aggregates. Therefore, the answer to your question, do I know any individual, the answer is no.

Q. Do you know whether any of the class representatives were misled?

A. What is a "class representative"?

Q. Do you understand that there are certain people who are bringing this lawsuit?

A. Right.

Q. And that they are bringing this lawsuit on behalf of others? You have to answer out loud.

A. Yes, I do. I do know that.

Q. And you don't know any of their names, I take it?

A. That's correct.

Q. Do you know where they're from?

A. Other than Florida, no.

Q. And I take it you therefore don't know whether any of them were misled by anything the tobacco companies may have said or failed to say; is that true?

A. Again, my answer is no, because I deal with effects on the aggregate. I don't

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know the effects on the specific individuals.

Q. Do you know of any study dealing with populations demonstrating that any of them were misled by anything tobacco companies said or failed to say?

A. No. I'm not maintaining that I have evidence, per se, that they were misled, other than the fact that people kept smoking.

All I'm stating here is that the frank statement and similar kinds of pronouncements by the tobacco industry were misleading and were not based on the information available in the public health literature.

Q. You'll agree with me that there were prominent scientists in the 1950s who did not accept the view that smoking was causally connected with lung cancer; is that true?

A. Again, the answer is yes and maybe. Certainly yes, in the early part of the '50s, there were prominent scientists who were skeptical. But by the end of the 1950s, I know of very few prominent scientists, although there were a handful by the end of the '50s. But they were not substantial

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numbers.

Q. These scientists include Dr. Berkson; is that true?

A. I wouldn't consider Dr. Berkson particularly prominent. And he was not a well-known person.

Q. Are you speaking of Dr. Joseph Berkson?

A. Yes.

Q. Didn't you call him in your book, "A Smoking Gun," the dean of American medical statisticians?

A. I don't believe I did, Dr. Berkson. I think I talked of Dr. Raymond Pearl in that particular matter. But I don't recall.

Q. Let me direct your attention to page 110 of your book, "A Smoking Gun," and ask you at the top, on the left, whether that refreshes your recollection as to whether he was regarded as the dean of American medical statisticians?

A. Yes, you're correct. That's what I said in the book.

I maintain he was not a

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particularly prominent player in the causation of human cancer. And the fact that he disagreed -- at very most, he would be part of the handful of scientists that I referred to as being dissident on the subject by the late '50s.

Q. And Dr. Ronald Fisher, do you know Dr. Fisher?

A. No, I don't.

Q. Are you aware of whether he has also been characterized as a father of modern epidemiology?

A. No. His name is quite obscure to me.

Q. Let me go back. You talked about the tobacco industry making a conscious decision; do you recall that? You used those words when I first asked you about your statement in the disclosure.

A. Yes, I said that by presenting full-page newspaper ads, that was a conscious decision. And that misrepresented the facts.

Q. But you don't know one way or the other, doctor, whether the tobacco industry

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consciously was intending to mislead people or not, do you?

A. Well, I have two alternatives here. Either they were consciously misleading the people by putting a frank statement out, or they were totally ignorant of the facts that were available in any medical library to them. And since I know the latter is not the case, I'm choosing the former.

Q. Well, don't you think they were free to accept the views of Dr. Berkson as opposed to the views of some of the scientists that you referred to?

A. I would not have minded in the least if they had concluded Dr. Berkson's views. But the omission of the most significant studies in epidemiology to date, namely those published in the Journal of the American Medical Association in 1952, and the British Medical Journal, shows that they made a conscious decision, in my opinion, to omit reference to these prominent prospective studies.

Q. Is it your view that when someone

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makes a statement about a medical or scientific issue, they ought to always also cite or refer to opposing points of view?

MR. HOAG: I object to the form of the question.

A. I don't believe that they should necessarily reference opposing points of view, if they are kind of aberrant, on the fringe. But when they omit reference to the current mainstream medical literature, that is another question, and I believe that represents a conscious decision to withhold information.

Q. Well, hasn't your organization been accused of failing to acknowledge mainstream medical literature on a variety of subjects?

A. I can attest that in twenty years, I've never had that charge leveled against me or my organization in any legitimate fashion.

Q. The statement talks about a fraud with respect to the public, but also local, state, and national governmental authorities and agencies.

Do you see that?

A. Yes.

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Q. Do you mean to differentiate -- or do you differentiate between anything that was said or not said to the public and things that were said or not said to governmental authorities and agencies?

A. I think it's mainly what was said to the public, and that itself influenced what was pursued by local, state and national authorities.

And local, state, and national authorities are part of the public.

Q. Do you have any knowledge with respect to whether or not any state or local authority in Florida was in any way affected by anything the tobacco companies said or failed to say with regard to the issue of smoking and health?

A. I'm not specifically familiar with the activity or lack thereof in Florida.

Q. The next sentence in the disclosure states that, "Dr. Whelan will testify as to the suppression, distortion and destruction of internal tobacco scientific and medical research in an effort to hide the dangers of

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smoking."

You intend to talk about that, doctor?

A. Yes. As I mentioned, I'm interested in discussing both the disinformation as well as the misinformation. And the disinformation would be the omission of discussions of the dangers of smoking.

For example, in popular magazines.

Q. Let me go back to that for a second. You mentioned that -- do you think tobacco companies had any direct influence on what was published in magazines?

A. I think in advertising dollars, which are surrogates for them, did have an influence on what was reported in the editorial copy of those magazines.

Q. So you're not saying that anyone from tobacco companies told anyone at a magazine in this country not to publish an article or to change an article, are you?

A. I might, if there were specific cases. There may be some specific cases. But more generally, simply the presence of the

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advertisements and the revenue generated by them was enough to chill any discussion of the dangers of smoking.

Q. Let me ask you, then, specifically: When you say you might, do you have any specific example of any tobacco company requesting that a magazine not run an article or change an article?

A. Right off the top of my head, I do not. I don't have any specific example of where the industry's representative, him or herself, made this request. But simply the presence of the ad dollars and the knowledge on the part of the editors of the ad dollars would not be forthcoming if negative commentary about smoking was concluded, was enough for pressure.

Q. So in a sense this was all going on in the minds of the magazine editors; correct?

A. No, it's not correct.

Q. How is it not correct?

A. I do know of some specific instances where the industry has actually removed cigarette ads from a magazine following the

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publication of pejorative commentary on smoking.

Q. Can you distinguish pejorative commentary from scientific reporting?

A. No. I would say, because the scientific reporting is all negative or pejorative, that it would be synonymous.

Q. Can you cite those examples for me now, please?

A. In 1980 I held a press conference in San Francisco to release a study that we've done on magazines and their failure to report on smoking, and at the time of that press conference we brought in the editor of, I believe the magazine was "Mother Jones," who offered testimony, if you will, in this press conference to the effect that having done an article on the dangers of smoking, he lost the magazine, at least temporarily lost the cigarette revenue.

Q. But has since regained it?

A. No. They don't take cigarette ads now. I don't know if they have subsequently regained it and lost it again.

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Q. Do you consider "Mother Jones" a reliable magazine?

A. Reliable in terms of this particular man's testimony as an editor and in describing his advertising revenues, I considered it reliable. I'm not prepared to comment on the reliability of the text of the magazine.

Q. They have published a number of articles critical of your organization, have they not?

A. They could. They have also published things positive on me, as well, so I don't know.

Q. Aside from that example, are you aware of any other instances where you believe that cigarette advertising was pulled because of an article, or the threat of an article, or the possibility of an article in a given magazine?

A. I cannot give you other specific instances involving tobacco. However, I am a friend and colleague of many, many magazine editors who have confirmed to me over the years that advertisers are very sensitive to

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copy, the editorial copy about their product, and will punish, if you will, by removing advertising revenues.

Editors are very sensitive to this. And the fact that cigarette ads are so prevalent, in my view, has suppressed the free flow of information in the magazines about the dangers of smoking because they don't want to lose the ads.

Q. When an editor is concerned about running an article critical of a non-tobacco advertiser, would you also regard that as evidence of fraud on the part of that non-tobacco advertising?

A. First of all, let me say that the pressure on editorial copy from non-tobacco advertisers is also substantial; that editors have told me consistently that they will not criticize an advertiser for fear of losing that revenue.

The distinction here, of course, is that the other products they're advertising are not inherently dangerous, or are not the leading cause of premature death, and not

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dangerous when used as intended. So that would not constitute a fraud in that sense.

Q. Would it be correct to say, doctor, that you do not know for a fact that the cigarette industry knew anything about the risk of lung cancer that was not generally known in the scientific and medical community?

A. In terms of known for a fact, I don't know how really to address that, but I have come to strongly suspect that the cigarette companies had far more information about the dangers of smoking that are even in the literature, that they had their own studies; that they were aware of studies from Europe that were not widely available in this country; and that they were -- knew very early on the mounting evidence that cigarettes were hazardous to health.

Q. Well, that's not really what I'm asking you. You're a scientist, you don't act on suspicion, correct; you look for actual evidence, don't you?

A. Actually, no. If there is suspicion, I would act upon that.

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Q. Do you take that tact with all of the different substances that you address in your many newsletters?

A. Absolutely not. There comes to be a point where, when there is human epidemiological evidence that something is hazardous, even though there isn't the so-called consensus that we've much discussed, that there would be time to warn people.

I have never rejected information of that type as being something that should be withheld from people.

Q. In any event, leaving aside your suspicions, do you know for a fact and are you able to testify under oath that the cigarette industry knew anything about the risks of lung cancer that was not generally known in the scientific and medical community?

A. My review of the Brown & Williamson documents, and other -- I'll leave it at the Brown & Williamson documents, indicate to me that the cigarette industry had its own data with cigarettes and the ill-effect, and its effects on health.

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Now, exactly what they had when versus what was in the literature, I have not really done a time line comparison at this point.

Q. So the answer is no, you don't know that they knew anything about the risks of lung cancer that was not generally known in the scientific and medical community?

A. I do not know right now. But on the other hand, I can go easily look it up, and from the collection of released documents, I can make the comparison. And I can do that at any time. And I suspect that I will find examples that they did know more than there was in the literature.

Q. To the extent that you do that and intend to testify about it, I would like to know about it so I can ask you about it prior to trial.

(Luncheon recess taken at 12:15 p.m.)

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AFTERNOON SESSION

(1:10 p.m.)

ELIZABETH WHELAN,

having been previously sworn, resumed the stand and testified further as follows:

CONTINUED EXAMINATION

BY MR. DODDS:

Q. Dr. Whelan, I would like to go back to the sentence in your disclosure statement regarding the fraud, and I just want to have a clear idea of the instances that you are intending to testify about. You mentioned the 1954 frank statement; correct?

A. Yes.

Q. And I believe you also mentioned the magazine articles.

Are there other examples or evidence of this fraud to which you intend to testify that you can give us?

A. Yes. The tobacco industry, through the Tobacco Institute, regularly published -- I think they called it "Tobacco and Health" newspaper that purported to report about

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current research on cigarettes and health. All it ever did was publish so-called negative findings. It was not representative at all of what was going on in the literature.

Q. Have you heard it said, doctor, that negative findings are difficult to publish in the peer-reviewed literature?

A. Yes, I have heard that.

Q. So it's conceivable, then, that the Tobacco Institute was trying to publish negative studies that would not have otherwise found their way into medical literature?

A. Well, these were not medical reports. These were the for-popular consumption. It was a magazine meant for laymen. It reported on even some peer review literature that would be sort of, perhaps, ambiguous or however they would interpret it was. It was not simply unpublished material. It was both.

It was the views of these handful of scientists who through the '50s and early '60s still resisted the causal link of smoking and disease. Their very unrepresentative views

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were given a substantial amount of coverage in this publication. But there are others as well. I recall one, for example, an advertisement, I believe it was by RJ Reynolds in the '70s, that purported to report on the findings of the so-called MRFIT study, the Multiple Risk Factor Intervention Study, if you looked at what were the causes of heart disease.

And this widely-published full-page advertisement claimed that the MRFIT study did not indict cigarette smoking as a cause of heart disease, when indeed it most certainly did.

So that was an example, in my mind, of a complete misrepresentation of the facts, through a paid ad.

Q. Going back to this newsletter, "Tobacco and Health," do you know what its circulation was?

A. No, I do not.

Q. Do you think that the scientists whose work was described therein were dishonest or intended to defraud anyone?

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A. I have no understanding of what the motivations of these scientists were. All I'm maintaining is that the publication of this so-called newspaper did not in any possible way reflect the mainstream views about smoking and health.

Q. Wasn't the whole idea that it would present an alternative view; don't you think readers understood that?

A. It was never described as being an alternative view, no.

Q. You don't think that readers would understand that a collection of medical articles coming from the tobacco industry, or any industry, would be likely to represent that industry's view on the science?

A. Well, I think perhaps it did reflect the industry's view on the science, and I'm saying it was a dishonest view.

Q. So, in other words, you are saying that the scientists whose views are represented in the articles were dishonest?

A. No, I'm not necessarily saying that at all. I'm saying the industry that

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selectively picked out these studies and statements from the full spectrum of commentary and published studies that were available, they were dishonest in presenting only a sheer fraction of the information that was available.

Q. The remainder was already in the medical literature; isn't that true?

A. Yes.

Q. So do you know of anyone who was misled by anything that was contained or not contained in the "Tobacco and Health" publication?

A. I would maintain that anyone who -- any layperson who read that and had no access to the medical literature, which most lay people don't, would be very much misled by this.

Q. Do you think that people would regard TI as a more credible source of information than a Surgeon General?

A. First of all, these appeared even prior to the Surgeon General's report.

Second of all, the Surgeon

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General's report occurred on one day, with the flurry of activity around that one day, perhaps for a week.

These were regularly published over the course of at least ten years, if not more.

Q. I guess I'm not sure you answered my question. Do you think that a person having read the Surgeon General's report and an article or a magazine entitled "Tobacco and Health" was more likely to believe the magazine as opposed to the Surgeon General?

A. I don't know of anyone who read the Surgeon General's report, so I couldn't make that -- I don't know any layman who ever read the Surgeon General's report.

Q. By the same token, you don't know any layman who read this publication either, do you?

A. Not specifically, no. I know it was widely circulated, but I don't know the circulation.

Q. With respect to the MRFIT study, you disagree with the tobacco companies' interpretation of that data?

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A. It wasn't their interpretation of the data. They misrepresented the data. The conclusions of the article were that cigarette smoking was a very highly established risk factor for coronary heart disease. That was the conclusion of the study, and they misrepresented it. It was not an interpretation.

Q. Well, did the MRFIT study conclude that any of the interventions studied in there was actually effective in reducing the incidence of cardiovascular disease?

A. If you look at the subset of people, not the intervention necessarily, but the subset of people in the MRFIT study who actually gave up smoking, they had a reduced risk of heart disease, yes.

Q. Do you know whether or not that population of people who quit, whether there were any controls placed on data relating to them to account for confounding factors?

A. I would have to review the complete methodology of the study to answer that question. The only thing I'm maintaining here

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is that the RJ Reynolds Company, in nationwide ads, misrepresented the conclusions of the authors of that study regarding heart disease.

Q. Do you think that someone is entitled to look at the data generated by a study and reach different conclusions than those of the authors?

A. No, I do not. Particularly when they attribute the so-called conclusions of the studies to the study itself. If they had taken out a study that said we reinterpreted this and we disagree with the authors, well, that might be a different matter.

Q. So we've now talked about the 1954 frank statement, the magazine articles, "Tobacco and Health," and the full-page ad regarding MRFIT. Is there anything else that you would refer to?

A. Yes. There were other statements, public statements, other advertisements, other publications where the general theme of the tobacco industry -- Tobacco Institute, speaking for the industry, was that the case against cigarettes as a causative disease was

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unproven. This stance was maintained through the '50s and well into the '60s, and only modified somewhat about the mid-1970s.

Q. Would you agree with me that it's difficult to judge what people were saying about causation in the '50s by the standard of the 1990s?

A. I'm not applying the standards of the 1990s, so I can't answer -- I can't say whether it's difficult or not. I'm not applying those standards.

I'm saying that they were misrepresenting the state of knowledge at the time. That's what was such a serious concern to me.

Q. Well, their conclusion, as you've related it, doctor, was that the case against cigarettes with respect to lung cancer was unproven. And you understand that the criteria that they were applying for proof of causation was different than the criteria that others might apply; correct?

A. No, I won't say that is correct. I would like to respond to that about whether

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their criteria is different by stating that they had no criteria at all. They were rejecting the consensus that cigarettes were hazardous without ever setting forth what their criteria was.

Starting in the mid-1980s, I began to seek direct information from Mr. Kornegay, who was then the chairman of the Tobacco Institute, and I asked him just that question in repeated correspondence. I asked him, since he rejected the statement that cigarettes were hazardous to health in specific ways, I asked him what evidence he would accept that cigarettes are hazardous, and what methodology, what criteria was he using to reject the current 60,000-plus references.

And I repeatedly asked that question -- that correspondence was published and widely circulated -- and his response was nil.

So I reject the fact that they had a vocalized criteria by which they were rejecting the current statements of causality.

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Q. Suppose they were using the criteria, traditional criteria. Do you know what that would mean in the context of proof of causation?

MR. HOAG: I object to the form of the question.

A. I apparently used the term "traditional causation" in one of the depositions you showed me. And what I was referring to was the criteria as applicable to infectious disease under Koch's postulates, which is not relevant here for epidemiology.

So when you say "traditional," I meant traditional in terms of disease causation for communicable infectious diseases, not chronic. So I don't know what you mean by "traditional."

Q. Well, I guess I'll accept your definition for the purposes of my next question. If the tobacco companies in the 1950s were applying the traditional criteria for causation, the evidence with respect to smoking and lung cancer would not yield a conclusion of causation, would it?

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A. If you're asking me if the tobacco companies insisted upon meeting the criteria associated with communicable and infectious disease for chronic disease, then no, of course, causation would not be in it. It never would be in.

Q. Now, the criteria that you mentioned earlier in your testimony today, when were they first published?

A. I really can't remember that. I do not remember the dates that they were first published.

Q. Do you have any reason to believe that they were published during the 1950s?

A. No. It may have been later than that, someone analyzing exactly what the standards for measuring the strength of the association should be, and what elements should be there before causation is claimed.

Q. Without reiterating the litany of evidence regarding fraud that we've just gone through, is there anything else that you would point to, Dr. Whelan, in support of your testimony regarding fraud?

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A. I'm not sure how up-to-date we are being on this, but certainly the testimony of the tobacco executives before Congress in 1992 -- I have it on my wall but I don't remember the exact date -- where they denied any knowledge of the causal link of smoking and disease, or smoking and addiction, would be another example of complete misrepresentation, blatant misrepresentation of the facts.

I mentioned publications that the industry did. As I said, I don't have all my files and notes which would detail the specifics. But another one comes to mind. The publication of the so-called "Guide for Parents Helping Youth Decide," which the Tobacco Institute came up with. I would characterize that as a complete disinformation and misinformation. Indeed, nowhere in the document did the Tobacco Institute ever explain why children should not smoke. And they went so far as to simply say that it was an adult habit. It was a complete distortion of what was known about smoking and health at the time.

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Q. Let me ask you, Dr. Whelan, going back to the Congressional testimony. If the tobacco executives who testified were using proof of an actual mechanism as the criteria for determining whether causation has been proven, their testimony that it had not been proven is in accord with the facts; isn't that true?

A. Not necessarily. If they had described what particular data were missing in their definition of causation, as I had asked many times, and if they were to describe the methodology for ascertaining that data, I might have more sympathy for their argument.

But neither of those requests have ever been met by me or anyone else who had ever asked.

So no, they are basically saying we do not accept the evidence, we do not accept causality, and will not explain to you what mechanisms or what methodologies we would accept to prove causality to our satisfaction.

Q. Assuming that they would accept, for the moment, proof of a causal mechanism, would

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their testimony not have been accurate if no such causal mechanism has yet been established?

MR. HOAG: Objection to the form of the question.

A. We all live in the same world and have the same language, or most of us, anyway, and no, I think there is no legitimate case to be made for people going, in a sworn statement or in a public statement, using definitions that are not commonly employed by the majority of the population. For them to define their own words, no. And they did not define their own words.

Q. We have already gone over the fact that certainly at various points of time scientists, at least some scientists, have felt that you need proof of an actual mechanism in order to make out causation; is that correct?

A. No.

Q. You don't think any scientist, any respectable scientist has ever taken that view?

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A. I don't know of any respected public health epidemiological scientists who have ever maintained that point of view. As a matter of fact, we as a profession maintain just the opposite; that we do not need a biological hypothesis and that we should move ahead with action in light of epidemiology absence. And maybe later on, you know, we'll figure out exactly why chimney sweeps get scrotal cancer and why the Broad Street pump caused disease, but right now we just know what happens and let's take preventive measures.

Q. You'll agree with me that the issue of preventive measures and the issue of what constitute cause or not are not necessarily the same?

A. Speaking specifically of the testimony before Congress, the U.S. population knew the question that was being asked and knew the words, the causation, and were not privy to some arcane, unique definition that these gentlemen had in answering. No, they were perceived as totally misrepresenting the

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facts.

Q. Well, if they were perceived as totally misrepresenting the facts, was anybody, to your knowledge, actually misled by anything that they said?

A. I could hypothesize that there were addicted smokers who were very happy to be relieved of some cognitive distance at the moment and had hoped that they were correct.

Q. Aside from your hypothesis or speculation, you don't think anybody was misled, or you don't know of anyone, do you?

A. I don't know that anyone wasn't misled, either.

Q. So you're not able to address it one way or the other; is that right?

A. I think I am able to address it as a public health educator. The impact of misrepresentation, not only on that day, but over the previous three decades had on keeping the message from permeating the decision-making process of the smoker.

The industry, which should know more than anyone else about the properties and

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dangers of its product, was denying that its product was causally linked with disease, and I think that probably had a very major impact on a person's decision either to begin smoking, continue to smoke or decide not to even attempt to quit.

Q. Well, let me ask you, doctor: The epidemiologic criteria to which you referred were not published until the 1960s. And if in the 1950s the industry was taking the view, based on traditional criteria, their view that causation hasn't been proven is really unchanged since that point in time; correct?

A. The industry's position?

Q. Right.

A. That could be. But, you see, that's the important point. The industry has never published what their position on causation is. That is a critical point.

So they are rejecting the mainstream science structure for causality without ever presenting to us their own criteria by which they would accept causality.

Q. Doctor, do you know of any other

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industries that publish criteria on causation?

A. I don't know of any other industry that, A, has inherently hazardous product; and, B, is denying that their product is hazardous in contrast with the mainstream of literature.

No, I can't think of anything, because tobacco is truly unique.

Q. Your answer is no?

MR. HOAG: Objection, she answered the question.

A. My answer is no, with the thrust.

Q. All of the other stuff.

Q. Other than what we've covered so far sitting here today, can you think of any other examples of fraudulent statements or omissions?

A. There are numerous ones, numerous ads that the tobacco institute took out over the last few decades.

I remember one that said let's have an open dialogue about cigarettes, as if it were still something we could, you know, there's this side and that side, and we're having a

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little debate on this, inviting people to call in an 800 number and talk about, you know, these two sides, when indeed there are no two sides.

Again, it was the analogy of having a discussion of nuclear physicists and the Platter Society. You could postulate that these were a debate, but the debate was really a phantom debate.

Q. Anything else?

A. There are so many. I mean those are the ones that immediately come to mind.

Q. Sitting here today, that's what you can think of?

A. Those are examples of it, yes.

Q. Turning to the next sentence regarding suppression, Dr. Whelan. Do you have any personal knowledge regarding suppression by the tobacco companies of any internal research?

A. The only information that I had reviewed is that in the Brown & Williamson papers. And I haven't reviewed that for some time now, but there were examples of industry

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memos discussing laboratory work that had been done by the industry.

Q. And by Brown & Williamson papers, you're talking about the documents published in a book called "The Cigarette Papers"?

A. Yes.

Q. And so your knowledge is basically predicated on having read that book?

A. Yes. I have not had direct firsthand experience with many of the internal documents. But there have been some recent media reports, which I am reviewing and getting more information on, about the availability, particularly in Europe, in Germany, of pretty hard data from retrospective studies linking smoking and lung cancer as early as 1940 and 1942.

And as I reviewed these, which were released by a wire service last week, I had to assume that if this was available -- this was particularly out of Germany, out of Nazi Germany, and the published studies there on this subject as early as 1941 and 1942 -- it just would appear to me that this was so

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well-known in Europe, as early as that, I cannot believe that the American cigarette manufacturers were not equally as aware of this data and observations.

Q. That's really supposition on your part; is that right?

A. It is a supposition based on, I think, some reality.

Q. But you're really guessing?

A. I'm hypothesizing that if this knowledge were so widely available in Germany, that it would be also available to American counterparts.

Q. Do you think there was some flow of communication between the Nazis and the tobacco companies?

A. I am talking about German scientists, not necessarily what their political views were. If German scientists were well into studying this in the early '40s.

Q. What about destruction of medical or scientific research; do you have any personal knowledge on that subject?

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A. No, I don't have any knowledge necessarily about destruction. But I have reason to believe that much of the research funded by the tobacco research interests never saw the light of day and were published in obscure journals and were not available.

Q. When you say you had reason to believe, is that just an impression of yours or from a specific document you're referring to?

A. It's my impression from reading, for example, Tobacco and Health, just reading, for example, the funding of the American Medical Association in 1964 by the Tobacco Institute for more research, I never saw the results of that research. I don't know what ever happened to it. It seems to me there was a great deal of so-called "research" being funded which never made its way into the journals.

Q. Do you have any specific knowledge of any specific study that was destroyed or suppressed?

A. No.

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Q. The disclosure statement goes on to say: "She will further testify as to the misrepresentations that have been made by the tobacco companies, Council for Tobacco Research, and the Tobacco Institute so as to dupe the American public into believing that there is no danger posed from smoking and exposure to secondhand smoke."

Let me first ask you: Does the American public generally believe, do you think, that there is no danger posed from smoking?

A. The surveys and the polls that I have seen over the years show that a very high proportion of those questioned say that they understand that smoking is dangerous. However, the questions have never really been posed in depth, and it is my impression and belief that Americans do not understand the specifics. They only know of cigarettes being dangerous in a very generic way.

Q. So, in other words, the American public is generally aware that cigarette smoking is dangerous; isn't that true?

A. I wouldn't like to say that out of

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context. They think smoking is dangerous, but I think they also think that saccharine is dangerous and PCBs are dangerous and that lead is dangerous. And I've never seen any data to suggest that they think cigarettes are more dangerous. Nor have I ever seen information to indicate that they understand under what circumstances cigarettes are dangerous.

For example, how much you have to smoke, how long you have to smoke, what types of cigarettes you have to smoke, what types of synergistic exposures you may also have. I don't think they understand it relative to the background noise hazards around us.

MR. DODDS: I would like the reporter to mark as the next exhibit, Defendant's Exhibit 6, an article entitled Cigarette Colonialism, by Dr. Whelan and Margaret Sheridan of USA Today, 1981.

(Defendant's Exhibit 6, for identification, article entitled Cigarette Colonialism, by Dr. Whelan and Margaret Sheridan of USA Today, 1981.)

Q. Do you recognize this document,

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doctor?

A. I most certainly do not. I am seeing articles today I haven't seen in twenty years. I'm amazed.

Q. You don't deny that this was an article you co-wrote with another author?

A. I don't deny it. My name is on it.

Q. Turning to the second page, doctor, in the left-hand column, there is a paragraph about two-thirds of the way down the page that begins with a rhetorical question:

"What health implications? The question seems almost ludicrous to Americans who have been taught the hazardous facts on cigarettes for years. Isn't everyone aware of the relationship between cigarette smoking and cancer, heart disease, and other life threatening ailments?"

If people were aware of the relationship between cigarette smoking and cancer, heart disease and other life threatening ailments -- strike that.

You're suggesting that it isn't enough to be aware of the relationship. Isn't that

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right?

A. I'm saying it's not enough to have this generic message. My purpose here was to contrast apparently what was happening in particularly Third World countries versus the United States. I said even in Third World countries they don't even have the most minimal information about smoking and its relationship to cancer and heart disease.

I don't mean to imply in this statement that Americans have full knowledge themselves.

Q. Well, what you said was that Americans have been taught the hazardous facts on cigarettes for years; didn't you say that?

A. I said that here, yes.

Q. And you say that everyone is aware of the relationship between -- at least in America -- between cigarette smoking and cancer, heart disease and other life threatening ailments?

A. That doesn't necessarily mean that they're aware as it applies to them. Nor does it mean necessarily that they're aware of what

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level of smoking would be involved in this, and what extent and duration of smoking would be involved in it.

I think that people can be aware that there's this relationship, but not have it applied personally to their own decision because they don't have the specifics.

(Mr. Moodhe enters).

Q. Isn't that true with respect to every consumer warning?

A. The other consumer warnings that I am aware of are very, very few in number and relate to purely hypothetical hazards or one that involved misuse of a product.

MR. DODDS: I'm going to ask the reporter to mark the next exhibit, Defendant's Exhibit 7, an article from the Chicago Sun Times, July 28, 1985.

(Defendant's Exhibit 7, for identification, article from the Chicago Sun Times, July 28, 1985.)

Q. Do you recall having spoken with the reporter, Mr. Ritter, at the Chicago Sun Times with regard to an article he wrote that was

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published on or about July 28, 1985?

A. No, I do not.

Q. Do you see that this article in Exhibit 7 quotes you as saying: "People's awareness today of the devastation of smoking is overwhelming, and smokers are desperate for reassurance."

Was it your view, Dr. Whelan, that people's awareness today in 1985 of the devastation of smoking is overwhelming?

A. No.

Q. So is this quote wrong?

A. It's just incorrect.

Q. Did you call up Mr. Ritter and tell him he quoted you incorrectly?

A. No, because I probably never saw this article in print. I am not familiar with it.

MR. DODDS: Let's mark the next exhibit, Defendant's Exhibit 8, an article appearing in the Dallas Morning News on April 11, 1988, entitled "Tobacco Firm's Knowledge of Link to Cancer is Probed."

(Defendant's Exhibit 8, for

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identification, article appearing in the Dallas Morning News on April 11, 1988, entitled Tobacco Firm's Knowledge of Link to Cancer is Probed.)

Q. Let me ask you, Doctor, do you recall speaking with Mr. McDonougal, a reporter for the Dallas Morning News, in or about April of 1988?

A. No.

Q. Turning your attention to the last page of Exhibit 8, do you recall telling Mr. McDonougal, as is quoted here: "Everyone knows that cigarettes are killers, she said. No one, except for the tobacco industry, says otherwise. We know they are lying. They know they are lying, and we decided to get on with our lives."

Do you recall saying that to Mr. McDonougal?

A. No.

Q. Do you deny that you said it to him?

A. No.

Q. And, in particular, the statement, "Everyone knows that cigarettes are killers."

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A. Right. I don't know what the context of this is, but I would suspect I was referring to everyone in the public health community knows that cigarettes are killers.

Q. So you don't think "everyone" applies to everyone; it applies to someone, or some people?

A. I'm speaking again of that consensus, that the scientific community knows that they are killers, and that tobacco is the only one that people are saying otherwise, right.

Q. And you also say that everybody knows they're lying; right?

A. By 1988 everyone knew they were lying, yes. Not everyone, but most people knew that they were lying, yes. They were kind of like a joke.

Q. So after that, anything they said was not believable, in your judgment?

A. Well, that's a relative term. It depends on who is listening. Again, a cigarette smoker is probably desperate for information to justify his or her continued

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smoking, so they may say, well, he's probably not credible, but maybe if he keeps saying, there's still some hope that it isn't dangerous. Everyone knows that cigarettes are killers. I'm speaking of those knowledgeable about the medical literature.

Q. That's not what it says, right? It says "everyone," am I right?

A. Yes. But in what context? I'm speaking of everyone in the -- everyone who is scientifically knowledgeable knows that they're killers.

Q. The next sentence in the disclosure document, Dr. Whelan, states that you will testify about how the tobacco companies, CTR, and the Tobacco Institute have aggressively pursued litigation that attempts to reveal the truth that smoking causes disease.

What litigation are you referring to here, if you know?

A. I'm aware of instances, including relatively recent lawsuit filed against the University of California and Dr. Stan Glantz by members of the Tobacco Industry, on the

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grounds that some peer-reviewed article that Dr. Glantz published was misleading, and I'm not sure exactly what that grounds for the lawsuit were. But that would be a case for pursuing litigation against an institution.

Q. Do you know specifically who the plaintiffs in that lawsuit are?

A. No, I can't recall. I could look it up; I have it in my files at home, but I don't remember exactly who they are. I just know it was against Dr. Glantz and the University of California at Berkeley, I believe, San Francisco.

Q. Other than that case, are you aware of any other litigation along the lines described here?

A. Yes. I recall a case, I think it was in the mid-'80s in Chicago, where a journalist, I think his last name was Jacobson, though it wasn't Michael Jacobson, it was another Jacobson who was on a radio program in Chicago, I think it was WBBM in Chicago, where he made a claim to the effect that the cigarette companies were pursuing

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children to get them to smoke, and I believe that was also a subject of litigation by the cigarette companies suing this particular person, Dr. Jacobson, and perhaps even WBBN.

I am also aware of media reports that even our foremost TV networks, including ABC and maybe CBS, have been inhibited in their pursuit of tobacco stories under the threat of litigation by cigarette companies. And I believe there was even a settlement and a so-called apology from ABC because of the threat of litigation from a tobacco company.

Again, I forget a lot of topics I'm covering and I don't know the specifics, although I have the specifics in my files at home, but those are the examples that come to mind.

Q. Now, the network litigation you're referring to, the nature of that claim was that the network had, in fact, not told the truth; isn't that right?

A. I don't know. As I said, I don't remember the specifics, but -- let me see.

(Pause).

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I would have to review that. But you asked me for an example, and that would be one of the examples that I would be conversant on.

Q. And in that instance, the network apologized for not having told the truth; isn't that right?

MR. HOAG: I object to the form of the question. It misstates the facts. The facts speak for themselves.

MR. DODDS: The whole idea of a deposition is to get at the facts. My question to the witness stands.

MR. HOAG: Not to misstate them.

A. As I recall that case, the producer and writer of the program were extremely unhappy that the settlement was made, and their apology was rendered, and that they stood by their story that there was not misrepresentation. But, again --

Q. But the network apologized; right?

A. The network capitulated and apologized.

Q. Any other litigation?

A. I can't think of anything right now,

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but I cannot say that I do not have other examples because there probably are other examples that are not coming up to mind right now.

Litigation and other means -- have we gotten to the other means? Because that's part of the same question. I have other means, but not litigation examples.

Q. Yes, okay. Let's go to "other means."

What other means will you testify to at trial, doctor?

A. There have been a number of times in my professional career that the cigarette industry has intervened to keep me from talking of the dangers of smoking in public forums.

One instance I have in mind occurred approximately 1990. I was invited to be a keynote speaker at the Grocery Manufacturers Association in Greenbrier. I won't go into all of the details of it, but at the very last moment the members, Kraft and Nabisco and General Foods, speaking for their parent

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companies, asked that I not speak about cigarettes in my talk at all.

And when I refused to do so, I was dismissed as a speaker.

There have been a number of other instances of that kind.

In 1977 I was scheduled to be a guest on Good Morning America to talk about a new book about preventing cancer. It was listed in TV Guide. It was widely publicized. And my appearance was cancelled hours before the appearance, and the then host of the program told me that he received a phone call from Philip Morris saying that if I were not taken off, there would be no more 7-Up ads on ABC, and I was taken off.

I would call that as other means against an individual to attempt to reveal truth.

There were other instances involved in being taken off podiums just before my talk, because I refused, under pressure from tobacco companies or tobacco subsidiaries, not to talk about the dangers of smoking.

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Q. You've mentioned, I think, two examples. You mentioned others. Are there others?

A. I can think of another instance. In about 1980 I was going to be a paid speaker to go to Hawaii to address the Pineapple Association of America, Delmonte, and RJ Reynolds Company was a member, and they instructed me not to talk about cigarette smoking.

Q. Other than these three instances, are you aware of any other examples of other means by which tobacco companies, CTR and/or the tobacco industry, have attempted to prevent people from telling what they know?

A. Yes. There are multiple examples. You know, I don't have them all in my mind right now, but I have noted a pattern in my life of the tobacco industry intervening to attempt to restrict the institution, namely my group, the American Council on Science and Health, from revealing the truth.

On or about 1985, the chairman of Dow Chemical showed me a letter from RJ Reynolds's

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chairman saying that there would be retaliation in terms of no more purchases of chemical supplies from Dow if RJ Reynolds continued to fund me.

Q. I'm sorry, you meant that Dow continued to fund you?

A. Yes, that Dow continued to fund me.

So I have seen a pattern of the long arm of the tobacco industry attempting to stop what would otherwise be a free flow of information by strong-arming people into not saying what they want to say, or threatening litigation, or otherwise pressuring to remove advertising or have other economic punishment, if you will.

Q. Can you testify under oath as to any specific effect that any of those actions had on any individual or group's understanding of the facts regarding smoking and health?

A. Specifically the group that I was going to address in Greenbrier didn't hear my talk on the causes of cancer, because I was taken off the podium because I would not acquiesce to the pressure to edit out the

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references to smoking lest I offend the member companies that were owned by cigarette companies.

Q. Do you think they were in any way misled as to what the dangers of smoking are by virtue of you not appearing at that forum?

A. Actually, yes. I think they were misled as to the relative dangers of things. Because my talk was not going to be just on smoke. It was a compare and contrast about causes related to disease, like alar on apples versus cancer, and Polynesian oils, palm oils versus cigarettes as the cause of heart disease. I think I had a unique perspective and, yes, I think that was something that they would never have heard before from someone else.

Q. I take it, doctor, that your organization has received funds from the makers of alar, as well as the makers of or producers of palm oil and other tropical oils?

A. We have. It's a very, very minuscule, less than -- in the case of alar, less than a fraction of one percent of our

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entire budget. So maintenance people are not major contributors. We do not speak for them, nor are we influenced by their very modest contributions.

Q. Doctor, the next paragraph of your disclosure statement states that you will testify that from the 1950s and 1960s, the tobacco industry has known that nicotine was an addictive drug and that smoking caused cancer and other diseases. Let me just stop at that point.

You are not an expert on addiction or addictive substances; is that correct?

A. Now we're back to the definition of "expert." I have some expertise in the sense of reading the tobacco literature for the last twenty years. I have, again, more expertise about addiction, I think, than most people walking around New York City today.

But I am not a pharmacologist, as we have already established.

Q. Do you have any specific knowledge of what the tobacco industry knew or did not know during the 1950s or '60s?

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A. My major, perhaps only source -- well, no, my major source is the Brown & Williamson Tobacco papers, with the various internal memos which talked about cigarettes being a delivery system for an addictive drug, nicotine.

I'm quite aware that the industry was well aware that they had an addictive substance, nicotine, in their product. And that was an essential part of their product.

Q. Doctor, do you believe that all smokers are addicted to tobacco?

A. I don't think all smokers are, no.

Q. Do you think addiction varies from smoker to smoker?

A. I think it can, yes.

Q. Would you characterize regular smokers as drug addicts who are unable to stop smoking?

A. I would say that the majority of regular smokers are unable to stop smoking, as manifest by surveys that tell us that 90 percent of current smokers wish they could stop smoking but they, for some reason,

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cannot. There is a very powerful course, habit forming, addictive, associated with the cigarette and smoking phenomenon.

Q. So do you think they're addicted and can't stop smoking, as a general rule?

A. For the majority of smokers?

Q. Just by virtue of being a regular smoker?

A. I would say a regular smoker of a pack or more a day, a substantial number of them are physically addicted and would have considerable difficulty giving it up. Though certainly there have been substantial number of people who have been able to terminate the habit, too.

Q. Do you think regular smokers are unable to stop smoking?

A. Some regular smokers are apparently unable to stop smoking, and they tell us that they're unable to stop smoking.

Q. Do you think they're right?

A. The fact that they want to smoke -- they want to quit, 90 percent of them, and they can't quit, suggests to me that they are

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correct.

Q. Would you agree that all new smokers start and cannot stop smoking?

A. No.

Q. Do you think that regular smokers don't possess the ability to stop smoking cigarettes because they're addicted?

A. I think a physical addiction -- and it really goes beyond a physical addiction. There are a lot of behavioral aspects of the grip of cigarettes on people, makes it very difficult for a substantial number of people to give it up, to the point where they feel hopeless and feel unable to quit.

Q. Do you think that they lack the ability to quit?

A. Who?

Q. Smokers.

A. All smokers?

Q. Yes.

A. I don't know what you mean by ability. They have obstacles to quitting, even though they wish to.

Q. Dr. Whelan, do you think there is a

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difference between a habit and an addiction?

A. I think there is an overlap there, yes, that can be teased out, yes.

Q. Do you know how the Surgeon General initially characterized smoking?

A. Yes. I know that there was a dramatic change in the addictive characterization of smoking from 1964 up to the early '80s. And I think early on, the 1964 characterization was one as habit forming.

Q. Dr. Whelan, do you recall writing a book called "Preventing Cancer"?

A. Yes.

Q. Subtitled "What You Can Do To Cut Your Risks By Up To 50 Percent."

Do you recall that you attached to your book, as part of the book, several appendices, one of which is a pamphlet put out by the American Heart Association; do you recall that?

A. I don't. I wrote that book back in 1976, so I don't remember anything about that edition of it.

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Q. Maybe referring to the book will refresh your recollection that there was such a pamphlet entitled "Tips for Kicking the Cigarette Habit" annexed to your book, Preventing Cancer (handing).

A. Yes.

Q. You attached this appendix because you thought it provided useful information to readers of your book, did you not?

A. I assume I did, yes.

Q. You will recall, doctor, that the book contains -- I'm sorry, the pamphlet, which is part of the book, contains a section entitled "Addiction Versus Habit"?

A. Yes.

Q. Do you see, doctor, that it states, in the American Heart Association pamphlet: "The reason you had been able to work on your own smoking cure is related to the fact that smoking is a habit, not an addiction."

A. Yes.

Q. It goes on to say that "Addiction refers to a physical or chemical change within the body that cues you to do something. While

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smoking may have brought damage to your physical health and well-being, and the continued process can trigger chain effects of disease, it is not a chemical addiction. It is a habit, a form of learned behavior you have trained yourself in. That is the reason you can learn to be a nonsmoker. And this is why thousands of smokers each year train themselves to be nonsmokers."

Was that a fair statement of your belief at the time that you wrote that book with respect to the question of addiction versus habit?

A. This, as you mentioned, is a document I've appended from the American Heart Association, so it is not -- it does not reflect my view. And, as a matter of fact, having written this book in the mid-1970s, I don't think I particularly had a view on that aspect. I didn't really focus in this book on cigarettes as addictive.

So it does not represent my view, and I don't think I had a view on this issue in 1975.

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But you've got to recall, as I referred to the American Heart Association statement here, does not reflect the mammoth change that came about in the medical community on the subject of addiction after 1980.

So this is kind of an anachronistic statement.

Q. Well, it was certainly the view of the American Heart Association, as of the time of its issuance in or about the late 1970s; is that correct?

A. That's correct. And I think it would be consistent with what was said in the first Surgeon General's report in 1964 about addiction versus habit. That was the prevailing view.

And I know that there was a dramatic change in the understanding of the addictive qualities of cigarettes after 1980. So this is something that is of the past.

Q. Do you think that telling people they're addicted helps them quit more than telling them that it's a habit that they can

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break, as the American Heart Association suggests in this pamphlet?

A. I think a little bit of both. If people understand the addictive component of what is the habit also, they might feel more willing to accept help, particularly pharmaceutical intervention, in terms of patches or gums or whatever else that could be offered; behavioral help.

To say it's only a habit and that you're totally in control and you should be able to do this cold turkey all alone because there's nothing except your will in this, I think that is overstating and putting a hundred percent of the responsibility on the smoker.

I think they should understand that it's a pharmacological component to their inability to simply walk away from it.

Q. Is it your intention, Dr. Whelan, to offer opinions directly on the question of whether nicotine is an addictive drug or not?

A. As we've discussed, my views on subjects such as health effects of smoking,

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addiction and smoking are those of my organization, the consensus group, and it is the view of my organization that cigarettes are an addictive drug.

Q. Now, the disclosure statement goes on to say that the tobacco industry developed -- or you will testify that the tobacco industry developed a fraudulent sophisticated legal and public relations strategy to keep this information away from the public, public health authorities and the courts.

Is that any different from the examples that you've already given us here today, or is it something more definite?

A. I think it's pretty much the examples that I gave you, in addition to observations, such as the tobacco industry fought fiercely to keep the warning of addiction off the cigarette pack. That has been something apparently very threatening to the industry, to use the word "addiction." That would be part of the blocking of this bit of information to the smoker.

Certainly the public statements

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recently from tobacco executives to the effect that cigarettes are no more addictive than carrots or gummy bears shows the extent to which the cigarette industry would parody this consensus view that there are addictive properties, addictive components, behavioral and pharmacological, to cigarettes.

Q. Doctor, other than what is set forth in this disclosure statement, do you know of other topics that you intend to cover in the course of your testimony?

A. No, I think this pretty much covers it. Though I am constantly trying to expand my knowledge and update my knowledge about what was known when, and who knew it, on all of these subjects.

I'm very interested in comparing and contrasting what the scientific knowledge was at a given date, say, 1940 to date; what the industry was saying publicly -- what the industry was saying in its private correspondence, as in the Brown & Williamson papers, and what the media was saying. I think that's a very interesting topic that I

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try to keep always up-to-date on.

Q. Do you anticipate discussing advertising or youth market?

A. I anticipate talking about advertising. I don't always make the distinctions, and my colleagues do, between the youth market and the general market. I think advertising generally doesn't deal to youth, and I'm not sure we can really segment them out very much.

Q. At one time, doctor, you took the view that cigarette advertising should be banned; correct?

A. I explored that possibility in some of my articles and editorials, yes.

Q. Well, didn't you come right out and say that they should be banned?

A. I recall writing one editorial once, when my two-year-old asked me why we were advertising a product that killed so many people, and I had to explain to a child -- and I couldn't explain it -- so I began thinking, well, why do we allow the continued advertising of a product that is inherently

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hazardous.

I reflected further on it, and to be more consistent with my own ideological views about government-solving problems, I realized that I had an inconsistency, and I began viewing the question in a different light.

Q. You will agree with me that in your book, "A Smoking Gun," one thing that you say is that cigarette advertising must be stopped; do you see that?

A. Yes.

Q. On page 144 of that book?

A. Yes, I understand that.

Q. And you have since changed your views on that?

A. Somewhat. I remain ambivalent about what should be done about cigarette advertising. My overall view, though, is that government intervention solving most of our problems is not the answer, and that simply holding the industry responsible, giving it the incentive to be more truthful, might itself lead to the phasing out of advertising without the government getting involved at

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all. So it could be just another means toward the same end.

Q. It's also the case, doctor, that you're skeptical about the link between advertising and smoking initiation and/or the continuation of smoking; isn't that also true?

A. I have written that I believe smoking has many different facets. It legitimizes smoking, it gives a rationale for people who smoke to continue smoking. It teaches a young person that this is an acceptable form of behavior. Gee, it's advertised. It's a very complex phenomenon.

Q. Understanding that, doctor, would you agree with me that there's no evidence that you could point to which, in fact, suggests there is a correlation between the degree of exposure of an individual to cigarette advertising and the probability that he or she will commence smoking?

A. I think it's part of a constellation of factors that I wouldn't pluck out as being the most important, but it's certainly a critical one. I think advertising plays a

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very major role of legitimatizing smoking and neutralizing any of the negative messages that particularly young people get.

I have objected most vociferously to the industry argument that this is a means of having people switch brands; it's brand competition. I think that is absolutely absurd, and that it doesn't do that at all.

Q. Doctor, do you recall being an author of a special report along with Ken Warner and John Holbrook and others on public policy on smoking and health some years ago?

A. I didn't know I wrote as much. Apparently I did. I don't remember that at all.

MR. DODDS: Let me ask the reporter to mark this as the next exhibit, Defendant's Exhibit 9.

(Defendant's Exhibit 9, for identification, article.)

Q. Looking at Defendant's Exhibit 9, this article, do you now recall this special report?

A. No, I'm afraid I do not. I don't

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remember this.

Q. Do you recall working with Mr. Warner and Dr. Holbrook and others?

A. No.

Q. Somehow your name got on this special report, however? Do you know who Mr. Warner is?

A. Yes.

Q. Do you know that he's a prominent author on smoking and health issues?

A. I know everyone here except Eugene Lewit.

Q. Do you know Dr. Holbrook?

A. Yes.

Q. Do you know he's an expert that has also been designated to testify in this case?

A. Yes.

Q. How did you know that?

A. Because his name showed up on the front page of something that was sent to me.

Q. How about Dr. Steinfeld; are you aware that he was listed to be testifying in this case?

A. His name was on the first document,

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No. 1 you gave me, had his name on the front of it.

Q. Directing your attention to page 387A of Exhibit 9.

A. Yes.

Q. The right-hand column, second full paragraph, second sentence states: "Most econometric evidence does not support conventional wisdom within the smoking-and-health community that advertising directly induces nonsmokers to become smokers, or smokers to continue their habits. To the contrary, the bulk of the evidence finds little association between changes in the aggregate level of advertising and changes in the prevalence or intensity of smoking."

Do you have any reason to disagree with that conclusion, doctor?

A. I don't agree or disagree with it.

Q. You don't know one way or the other?

A. I don't know one way or the other on that. All I know is that there's some reason that the tobacco industry spent $6 billion a year advertising. It's not to have no effect.

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Q. Well, when you say "advertising," do you think that they spend all of it on advertising?

A. And promotion.

Q. Promotion can be rebates to dealers and so forth?

A. Exactly.

Q. That's a little different from advertising, right?

A. Advertising and promotion.

Q. Are you aware of a recent article in the publication "Priorities" entitled "Should The Government Restrict Advertising Of Alcoholic Beverages? No.," by Dr. Morris D. Chafetz.

Do you know about that article?

A. I do know about it, but it's not an article. It's a point/counterpoint. And if you look on the other side of the page, it says should the government restrict the advertising of alcoholic beverages, and the answer is yes. So it's not an article; it's a two-part point/counterpoint.

Q. Your web site does not offer me the

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point to which it is accounting.

A. I think it does.

Q. Do you agree with Dr. Chafetz?

A. That?

Q. In his viewpoint that the government should not restrict advertising of alcoholic beverages?

A. I think I would agree with the thrust of his article, because he would agree that the government should restrict the advertising of alcoholic beverages to underaged children, specifically. I mean if he wouldn't object to the government -- object to the liquor industry advertising Weekly Reader, then he wouldn't object to the government intervening there.

Q. Doctor Chafetz says: "One study showed that the adolescents who drank alcohol could remember alcohol ads better than adolescents who did not drink."

He goes on to say, "But what does that prove?"

Do you agree that recognition of alcohol ads does not encourage or suggest that

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adolescents would be more likely to drink those particular brands or take up drinking than they otherwise would?

A. Again, my view on advertising is that it's more than just getting people to use your product on a given day or an immediate time frame. It's a recognition of the social acceptability of the product.

In the case of alcohol, that does not bother me, since it's a product that's safe when used as intended.

It does bother me when the advertising is of a product like tobacco, which is inherently dangerous.

Q. Doctor, you before suggested you did not believe that advertising was primarily directed at market share; is that right?

A. That's correct.

MR. DODDS: I would ask the reporter to mark as the next exhibit another article with Dr. Warner and others, the same group as the prior exhibit. This one is entitled "Promotion of Tobacco Products: Issues and Policy Options." And it's printed in the

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Journal of Health Politics, Policy and Law.

(Defendant's Exhibit 10, for identification, article entitled "Promotion of Tobacco Products: Issues and Policy Options.")

Q. This is an article that has your name as one of the authors. Do you recall having seen it before?

A. (Reading.) No.

Q. Do you think it's something that you saw before it was published?

A. I don't know.

Q. Does anything in it, to your knowledge, represent your views?

A. I don't know. I haven't read it. I don't know what it says.

Q. To the extent that it states on the margin the function of ad dollars would be to compete for existing market share, not to expand the overall market, that is something you disagree with?

A. Correct

(Recess.)

BY MR. DODDS:

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Q. Doctor, I wanted to go back and fill in some background matters before continuing on. Several years back you ran for the board of RJR; is that right?

A. Yes, I did.

Q. Can you tell me about that; how that happened and whether you were successful?

A. I hold one share of RJ Reynolds stock, and therefore I attended the board meeting in Wilmington, Delaware, and I was nominated for the board of directors by one of my public health colleagues. I took the occasion of my nomination to speak, to describe how I thought I would be an excellent board member in helping face potential litigation and what I would do, and I did not win election.

Q. Who nominated you?

A. I think Dr. Greg Connolly nominated me, as I recall.

Q. Did you have any genuine expectation that you might be elected?

A. I had a minor expectation that someone might hear my plea, because I thought

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I really could do something to improve public health and also save the company.

Q. Did you also think that your efforts might receive some publicity?

A. Yes.

Q. That was, in part, the intent, was it not?

A. This is correct.

Q. Is it also correct, doctor, that you have characterized your organization as the great defender of petrochemical companies?

A. No, that's absolutely false.

MR. DODDS: Let me ask the reporter to mark as the next exhibit, a reprint of an article from Consumer Reports of May 1994. Defendant's Exhibit 11.

(Defendant's Exhibit 11, for identification, reprint of an article from Consumer Reports of May 1994.)

Q. Doctor, are you familiar with this article from Consumer Reports?

A. Yes, I am.

Q. The title of it is "Forefront of Science or Just a Front"?

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A. That's right.

Q. And the last page of this reprint quotes a memo, or attributes a memo to you, does it not?

A. The last page -- oh, the very last page?

Q. Yes.

A. "According to Whelan, the bulk of ACSH's funding comes from not-profit foundations whose interest..."

"...One of the largest international petrochemical will not support action..."

I never saw this memo, and I don't know where it came from. I have protested to the Consumer Reports to produce it for me.

I have protested that they publish my letter. We are a great defender of science.

Q. So you did not ever write in this memo or elsewhere that your organization is the great defender of petrochemical companies?

A. No. These memos that were given to Consumer Reports were allegedly, or taken from my office by a dissident former employee who

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presumably could have doctored such memos or whatever. I don't know. But I would never describe ourselves as a great defender of petrochemical companies. Though the rest of this: "When one of the largest international petrochemicals will not support ACSH, one wonders who will," I do recall those aspects of a memo which I wrote, I think it was to the Shell Company, yes. Which is true.

But we would not describe ourselves or wouldn't describe ourselves as a defender. We defend science.

Q. I take it from the statements you made this morning, doctor, that it is not your intention to provide opinions concerning the question of whether smoking causes any of the enumerated diseases contained in your statement, but that instead you will confine yourself to talking about whether there is a consensus on that question; is that right?

A. I'm not sure what the distinction there is.

Q. Do you intend to go through, for the benefit of the jury, the epidemiologic

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evidence and the toxicologic evidence and other evidence supporting a conclusion that cigarette smoking causes any of those diseases?

A. It's the consensus of my organization that the, that cigarettes do cause these diseases. So if asked, I would state that.

Q. I understand. But as I understand it, there will be a variety of witnesses who are either cardiologists or toxicologists or epidemiologists or others, who have studied directly the question of smoking and health and will proffer opinions regarding causation.

Do you intend to offer those kinds of opinions, or do you intend to talk about the consensus of views?

MR. HOAG: I object to the form of the question. It implies that if she does one, she wouldn't necessarily do the other.

MR. DODDS: I'm not trying to imply anything. I'm just trying to get the facts.

A. I tried to answer the questions I was asked, whatever they were.

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Q. Are you familiar with all of the toxicological and epidemiologic evidence on each one of the diseases said to be associated with smoking?

A. I'm certainly familiar with the review articles as opposed to every individual article on coronary heart disease and smoking. So if there is someone there testifying about the role of smoking in coronary heart disease, that person would be better off doing that, then I would not get into that area rather specifically.

Q. Doctor, you have taken the position, have you not, that the warning label on cigarettes currently required by the United States government should be removed; isn't that true?

A. Yes, I have taken that position publicly.

Q. Is that still your position?

A. Yes.

Q. Did you ever have a contrary position with respect to the label?

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A. I never thought about the functionality of the label in any great detail until the late 1980s, when it became apparent to me that the label really served no one but the tobacco industry by offering it protection.

And that the answer to this broad cigarette problem was not more government intervention but less, and if the government had not gotten involved in that label in 1965, that we wouldn't be in this situation today.

So I came upon this sort of evolution of thought in the mid- to late-1980s.

Q. Do you feel that the current rotating warnings provide no useful information to smokers?

A. I believe they provide no useful information to smokers.

Q. And why is that?

A. Because they are missing the most important bits of data on dosage. They say cigarettes, you know, cause heart disease, cancer, emphysema, whatever. They don't tell you how much you have to smoke to have

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causation. They don't tell you how long you have to smoke. They don't tell you the degree to which your risk is increased. They do not mention what other habits or other life-style factors you should avoid to further increase your risk, namely, for example, mixing alcohol with smoking.

They are completely useless to the smoker, or prospective smoker, and they only serve the industry by offering the preemption from the otherwise inherent duty of the corporation to warn specifically about the dangers of their product.

And, yes, I reached the conclusion, and I've wrote on many pages in the last five years, that I think it would be beneficial to health to remove that label. Specifically, that we should never put the label on in the first place.

Q. You're not saying that no warning should be given; is that right?

A. I'm saying that the tobacco industry should be treated exactly as any other industry, with the full burden, 100 percent of

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the burden to warn on the industry. And the industry could determine the parameters of the warning that they felt was appropriate to protect them from being accused of not fully warning the consumer of the risk to be assumed.

Q. Let's say that a court decides or a jury decides that the existing warnings are sufficient?

A. Existing warnings as placed by whom?

Q. Let's say the tobacco industry decided to put on the exact same warnings that the government requires now, and a judge or a jury decides that that is sufficient to meet their duty under the product liability law, or indeed that no warning is necessary because it's open and obvious; would that change your opinion?

A. Theoretically it would. Except we really can't do this without rolling it back.

If you were to say to me would I accept if the tobacco industry had put that warning label, that one as it exists now by government mandate, or the one that was there

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in 1964 by government mandate, if the industry itself had placed that on, would that have been sufficient? If the juries determined that that was sufficient, I would say fine, I trust -- I would go with the juries. But they wouldn't.

And I believe that the industry would never have put that warning label on in 1964, because it was absolutely incomplete, by contrast, for example, with a pharmaceutical patient package insert which gives every single detail of what can go wrong.

So I would really have to roll back the clock on that to answer that question.

I think there comes a point that when the industry divulges the complete risks of cigarette smoking, if I were a member of the jury, I would say that cigarette smoker is on his or her own and I would attribute a hundred percent of the responsibility there.

The problem right now is it's not that way now, and it has never been that way.

Q. But in the event that whatever was determined to be full and appropriate

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disclosure is made, in that event do you think that the responsibility of smoking and any damage that may flow from that should be borne by the smoker; is that what you're saying?

A. I believe ultimately that that would be the case, yes. The exact parameters of how that would work, you know, would need to be defined. But eventually when there is full and complete disclosure, and that disclosure is made available in an understandable way to the consumer, and that he or she absorbs that, perhaps confirms that he or she knows that, and then still chooses to smoke, I would back away and say that that responsibility should be borne by the smoker.

Q. In fact, you've suggested that smokers get licenses, and that they be licensed to smoke after they acknowledge that they have absorbed a certain amount of information; isn't that right?

A. That is correct. I attempt to approach cigarette smoking within the framework of a philosophical belief that might be best described as conservative, and I try

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to be consistent in that. And I looked at smoking from that regard.

I think, as I proposed with the cigarette license, if one were to provide the information, determine that the person absorbed it, perhaps on a regular basis issued a license, that that would exonerate the industry from responsibility.

But we are light years away from that.

Q. How much information, doctor, do you think smokers need to know in order to appreciate that it's dangerous enough that they ought to consider whether or not to do it by reason of their health?

A. Well, I think they need some very specific information. I have actually prepared a book which I feel would be the basis of such a manual of a license. And the book is entitled "Cigarettes With a Warning Label Doesn't Tell You." It's a two-chapter book that the American Council on Science and Health published approximately a year ago.

In that there are twenty chapters

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written by twenty physicians in their specialties, and describe within each specialty what the effects of smoking are.

And it seems to me that, you know, generally speaking, this type of specific declaration to a would-be smoker or smoker would have a very powerful effect. Not on everyone.

But when people read, for example, that smoking is a major cause of blindness, macrodegeneration, cataracts; when young men, and I've given this to my daughter's friends, read that cigarette smoking is the leading cause of male impotence in men under aged 50, that might get their attention.

When they read about the very specific effects on coronary and lung function, as opposed to it's dangerous, I think this would definitely have an impact. And that's really all I'm asking.

I think I am distinguished from some of my other colleagues because I am not asking for anything except full disclosure and a truly informed decision. And I do think very

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few people would choose to smoke if they had this information.

Q. You said "might" a lot of times there, doctor. Do you have any efficacy data suggesting that additional disclosure would actually influence smokers' behavior or a would-be smoker's behavior in ways that the current labels do not?

A. I would have to say I have indirect evidence in the fact that if you look at subpopulations of, for example, physicians and ask what percentage of them smoke cigarettes, instead of being 25 percent, it's more like about, I think it's under 10 percent. And if you look at thoracic surgeons, it's down to around 3 percent. And that communicates to me that when people know the specific medical impact of cigarette smoking, that they would be more informed and less likely to smoke. And I propose that as an alternative. Whatever we're doing now isn't working, and I think it's an excellent alternative.

Q. Do you think that data regarding smoking behavior of thoracic surgeons is

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legitimate efficacy data sufficient to warrant a more detailed label or warning than is currently provided?

A. I don't think I really need efficacy data to argue in a free country in favor of making information available instead of suppressing it. I think the burden is on the other side, not on me, for efficacy data.

Q. Well, Dr. Whelan, when you were addressing the question of food labeling, do you recall that you wrote an article in "Priorities" magazine put out by your organization in 1993 entitled "Food Label Folly"?

A. Yes.

MR. DODDS: Let's have that marked as the next exhibit, Defendant's Exhibit 12, please.

(Defendant's Exhibit 12, for identification, article entitled "Food Label Folly".)

Q. In this article, which was reprinted from the Wall Street Journal, you disagree with the decision to require food labeling

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providing all the information that we currently find on food labels. Do you recall that?

A. Yes, I do.

Q. And you raise the rhetorical question in your article, what evidence is there that health benefits will follow from relabeling?

You go on to say: "Where are the efficacy data here to justify the consumer costs of relabeling?"

So in the case of food labeling, you wanted evidence and efficacy data to justify additional or further disclosure; isn't that true?

A. Well, there is a major distinction here. What I was objecting to on the food label is the disclosure of information that had no factual basis and was not of immediate relevance to the people eating the food.

It was clutter. It would do nothing -- it was not grounded in science. This is completely in contrast to citing risk after risk associated with smoking for every

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organ, every physiological system of the body.

I, for example, here objected to labeling cholesterol content of food.

What does it matter, particularly in the context as I argued here; it's only partial. You're not labeling natural things like -- this is labeling only processed foods. It's out of context; it's not useful. It is not scientifically based.

This is not useful in making a decision about whether or not to eat this food.

The cigarette label, as I'm proposing, and the full disclosure, is extremely useful on every count in making your decision.

Q. But the point, I guess, from this article is that you are calling for evidence that health benefits will flow, that people's behavior might change in a way that would improve their health.

Wouldn't you want the same evidence with respect to changes in the cigarette labels?

A. The cigarette label? Well, I don't

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know about a label. What I'm arguing for is not a label.

Q. Or a warning.

A. I'm not talking about a warning. I'm talking about full and complete disclosure. And I don't need efficacy data on that. If that doesn't work, there's nothing left in a free society. That's all I want, is the information out, and people able to have access to it and able to understand it and absorb it. And then let them jump off of a 50-story building if that's their choice; that's their life.

Q. The information -- you said before there are 60,000 studies out there, we are bombarded with information regarding cigarettes and health. Do you think that people are going to actually search out and absorb all of this additional information in a way that would change their behavior from that which they would carry out on the basis of the existing label?

A. I think, yes, I do believe this is a possibility. And I think, as I mentioned, my

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organization has presented the prototype for this already, so this is not hypothetical.

This particular guide that we have prepared to the health effects of smoking is easily read by a layman; it could be read within less than one hour, and it's comparable to, as I used my example in my writing, applying for a driver's license in the state of New Jersey where you are required to study a manual, demonstrate your knowledge of it, take a test, and then you're on your own. You're given a license.

Q. Do you have any studies suggesting that people who read that book behave in any manner differently than people who haven't read the book?

A. I have never done any studies. I have anecdotal information galore about how people have behaved differently when they have read what was in that book, yes. But I have no studies.

But, you know, in terms of the ultimate approach to this public health dilemma that we have of smoking, I don't need

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efficacy data personally. This is simply the disclosure in itself is all we can do in a free society. And if that doesn't work, if people will still go ahead and smoke despite the fact that they have absorbed this information, then there's nothing more we can do about it, other than discourage access of children. Other than that, there's nothing we can do with adults. Adults have to run their own lives. All I want them to do is have the information, and then once that's established, that's my sunset clause.

Q. But sitting here today, doctor, you're not aware of any studies suggesting that additional information made available to smokers or prospective smokers beyond what is contained in the current label, or which is otherwise, to your knowledge, to be of general knowledge, will influence in any way their behavior?

A. I have cited to you the only kind of surrogate data that I could come up with, and that's the prevalence of smoking among people, mainly men -- the studies have shown that

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mainly male physicians who, having access to this detailed information that I described on the dangers of smoking, have a very low prevalence of smoking.

Q. And nothing else that you're aware of?

A. I am aware of studies that have been done on so-called high, medium and low-fear education on smoking, where they show one group of smokers' operations, lung surgery and all kinds of grotesque cancerous lungs, and then the medium group less, and then the low, and they find the people who are really scared to death by these exposures may actually even smoke more.

I am aware of those. And I'm not proposing any high or medium fear. I'm talking about straight information.

Q. Haven't you suggested in the past that a warning label to disclose everything you would like it to disclose would have to be as big as a telephone book?

A. Yes. To get into a full and complete disclosure. But what I ended up -- I

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made it more concise in this form of this book.

THE WITNESS: Is this yours?

MR. HOAG: Yes.

A. This is the book, in case you're not aware of it (indicating). It was just republished as a book by Prometheus Publishers.

MR. HOAG: For the record, the court reporter can't get it down.

A. It's called "Cigarettes, What the Warning Label Doesn't Tell You, The First Comprehensive Guide to the Health Consequences of Smoking."

Q. Doctor, let me turn to a few questions relating to biostatistics. And I think we've indicated before, or you've indicated before that you didn't hold yourself out as an expert in biostatistics; is that right?

A. I have studied biostatistics as one of my doctoral areas at Harvard, not a particularly pleasurable one, so I don't pursue biostatistics in any big way.

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Q. You understand that there are a number of issues such as bioassays or confounding factors which can draw into question the validity of conclusions drawn from biostatistics; is that right?

A. I understand there can be something known as a spurious relationship that makes something look like they're linked, but there is a third factor unbeknownst that is actually masking a causal relationship.

Q. You've written in the past about problems with the various bioassays and confounding factors that make conclusions on the basis of epidemiologic data more difficult; is that correct?

A. I might have. It doesn't immediately ring a bell.

Q. You, for example, talked about death certificate recording data, in your book of the Complete Guide to Preventing Cancer; do you recall that?

A. Vaguely.

Q. In any event, you recognize that problems with death certificate recording

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data can have a problematic influence on epidemiologic studies; is that true?

A. Death certificate information is hardly perfect, but I would say that often -- it generally does provide a sound basis for epidemiology.

Q. You've also written, doctor, on the fact that lung cancer has been historically underreported; is that also true?

A. I don't recall ever writing on that, no.

Q. You have a publication called Health Watch, doctor, that's put out by your organization?

A. Many, many years ago, perhaps.

Q. Do you recall reporting on a study done at Yale New Haven Hospital with regard to lung cancer and the reporting of lung cancer?

A. No, I don't remember that, I'm sorry.

MR. DODDS: Let me have the reporter mark as the next exhibit a two-page document entitled "Health Watch," as Defendant's Exhibit 13.

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(Defendant's Exhibit 13, for identification, two-page document entitled "Health Watch.")

Q. Drawing your attention to the second page, under the heading "Study Coughs Up Undetected Lung Cancer."

A. Yes.

Q. You report here on a study done by Yale, suggesting that lung cancer statistics may be underreported. Do you see that?

A. Yes, I do.

Q. Are you aware that investigators have also said that most of those underreported instances of lung cancer were found in nonsmokers?

A. No, I do not recollect this. This is interesting and news to me.

Q. Doctor, are you familiar with the concept of reporting bias?

A. Yes.

Q. What is it?

A. A reporting bias could involve, for example, a case of a person with symptoms that are clearly lung cancer or throat cancer but

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who did not smoke, and the physician would be distracted by the fact that the person didn't smoke and perhaps not diagnose that immediately as what that disease really is.

Q. Would reporting bias also consist of assuming that a disease found that is statistically associated with smoking in a smoker, attributing that to their smoking?

A. You're moving away from the aggregate, which is what my area is, of epidemiology, to the individual attribution of smoking in an individual patient, which is really not something that I would address.

I look at large numbers of people, and the risk factors, the life-style factor here, particularly smoking, and what we find is that 90 percent of lung cancer is associated with cigarette smoking.

Q. But you'll agree that most smokers do not in fact get lung cancer?

A. I believe it's only about 10 percent of smokers who develop lung cancer. But we can't let that stand alone, because obviously lung cancer is only one of the land mines that

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cigarette smokers face.

Q. Do you agree that science does not know why some smokers get lung cancer and some don't?

A. Well, we do know some reasons, and that's because they die of other cigarette-related causes first.

Q. Aside from other reasons for mortality, does science know why some smokers get lung cancer as opposed to smokers who do not?

A. Yes. We have some reasons. We believe certainly that those who smoke more cigarettes, those who may have started at an earlier age, those who work with asbestos, would be much more likely. So we do have some knowledge about why some people are more likely to get lung cancer than others.

Q. But the truth is, is that two smokers with identical smoking patterns, one may or may not get lung cancer and the same is true of the other; we don't know why one might and the other wouldn't?

A. No, we don't. And perhaps in the

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future we will, and we'll be able to provide people with more information about what their individual risks are.

Q. And the same is true of nonsmokers; some might get lung cancer and some might not, for reasons that we're not aware of; is that true?

A. Yes. Again, I deal with groups and aggregates, not individuals, so...

Q. But even there are groups of nonsmokers who get lung cancer and there are nonsmokers who don't; is that true?

A. Yes. And there are nonsmokers who get lung cancer and who have been exposed to secondhand smoke, and there are some nonsmokers who have not been substantially exposed.

Q. Maybe so, but we don't know why one gets lung cancer and the other doesn't; isn't that true?

A. Well, we don't. As I mentioned, there are a lot of other variables that I've already mentioned, but we don't know all of the reasons.

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Q. Do you agree with me, doctor, that rates for lung cancer among smokers/nonsmokers vary from country to country, and also between the sexes?

A. Let's start. Do I agree that smoking -- I'm sorry?

Q. Rates for incidence of lung cancer vary?

A. Internationally?

Q. Internationally.

A. Yes, that's correct.

Q. A much higher proportion of nonsmoking women in China get lung cancer than do in the United States; is that true?

A. I really can't comment on that. There are a lot of factors there. When did the women start smoking? What kind of cigarettes do they smoke? What are their patterns?

I can't comment on that unless I would see the relevant variables.

Q. You do not smoke; is that correct?

A. No.

Q. And you never have?

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A. I have never smoked.

Q. What prompted you never to start, if anything?

A. I found it very unpleasant; the smell of it when other people smoked. I've been looking at the dangers, looking, professionally fascinated with the dangers -- I've been personally fascinated with it since I was in high school, and I've studied the effects of smoking then.

I pursued it as research projects. I was very, very aware of the effects of smoking. I just chose never to want to smoke; it was never attractive.

Q. Were you taught anything about the health effects of smoking in high school?

A. Yes, I was.

Q. Have you gone back in time to study what students in Florida were taught in school about the health effects of smoking?

A. No.

Q. Do you know what sorts of other information Floridians in particular were exposed to over the years with respect to the

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health effects of smoking?

A. No.

Q. Did you have friends in high school or college who began smoking?

A. Yes.

Q. Did they enjoy it at first?

A. I never asked them.

Q. We know, doctor, that about 50 million Americans have stopped smoking; is that right?

A. Over what period of time? People who are still alive, do you mean?

Q. People who are still alive, yes.

A. I don't know -- 50 million over what, since -- I would have to have a time frame of that to confirm that number.

Q. Well, 50 million Americans that are alive today that used to be smokers have stopped smoking; do you know that?

A. No, I don't know that for a fact.

Q. You don't know one way or the other?

A. I know people have given up smoking. I don't know that there are 50 million.

Q. Well, you know tens of millions have

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stopped; right?

A. Right.

Q. And you would agree that tens of millions of Americans have had enough information about smoking in order to make the decision to stop; isn't that also true?

A. I wouldn't conclude that. Maybe some of those tens of millions gave it up because they couldn't jog, or they couldn't have a peaceful life at home because their spouse wanted them to give it up. I don't know that they gave it up because of information. Maybe they didn't feel well and they decided they wanted to feel better. Maybe their kids nagged them to death about it and they finally gave up.

Q. But certainly of the tens of millions of smokers, millions have been able to smoke on the basis that they were concerned about their health and had enough information in front of them to make that kind of decision; isn't that true?

A. I don't know that's true. I think there's a lot of presumption there. I'll go

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with the fact that millions of people have given up smoking, but there can be many motivations for it, that had nothing to do with them having the information.

Maybe it was social acceptance. Maybe it was just considered it would hold them back in their jobs if they were ever perceived as smokers.

MR. HOAG: The last question you asked, I would just object to the form of it. I think you misspoke in part of it. You said "smoke," and you meant the opposite, I think.

MR. DODDS: Yes, okay, thank you.

Q. Speaking about jobs, do you think employers should be able to not hire people because they are smokers?

A. I'll start with the fact that I think employers should be able to restrict smoking in their work product. But you're asking beyond that, if people choose to smoke at home?

Q. Right.

A. That's a very difficult question. If I, as an employer, am to be assessed with

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higher health care costs for my employees, then for their life-style habits, or factors, perhaps certainly cigarette smoking would be the number one, it's the number one leading cause of death, on my mind.

Q. So is it your answer that you think that employers should be able to decide not to hire a person for the reason he or she is a smoker?

A. I'm not really -- I don't have a firm answer for that. It's sort of a legal issue, which I am not familiar.

If you ask me as an employer, would I not hire someone if they smoked, actually I probably would tell a smoker that he or she would be very uncomfortable working at my organization as a smoker.

On the other hand, if the person wanted to give up smoking and was a smoker and wanted to work for me, with that in mind I would not hire him.

Q. You don't have a definitive view on the subject?

A. I don't, no.

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Q. Would you agree, Dr. Whelan, that Americans are generally aware that it can be difficult to stop smoking?

A. Yes.

Q. Would you agree that there are lots of human behaviors that are difficult to stop?

A. Just backtracking to the first question. I think the majority of adults are aware of how difficult it is to stop smoking. I would not necessarily make that statement for people under age 20.

Q. Do you think that people under age 20 have more or less information about the problems associated with smoking?

A. I think young people are -- younger people under age 20 are less likely to know counterparts who have had great difficulty giving it up as an adult would, and therefore are not really familiar with the stubbornness of the cigarette habit in terms of trying to give it up. I think most young people are not aware that they could be making a lifetime commitment when they start smoking regularly.

Q. But you would agree that young

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people probably have more recent guidance on health effects of smoking than older people might; but what you're saying is that their life experience doesn't allow them necessarily to fully appreciate the potential problems?

A. That's correct. It's all theoretical to them, and it's always the impact of many, many years hence, and they have the rationale, in my experience, very frequently is that I will give it up when I am married and when I have children ten years from now. It's okay to smoke.

Q. Lots of women do in fact give up smoking while they are pregnant; is that right?

A. I don't know the figures on that, but I imagine many women do, yes. Not all.

Q. Getting back to my other question, there are any number of human behaviors that are difficult to stop; is that right?

A. Yes.

Q. Are you aware, doctor, that most people quit without medical or pharmacological assistance?

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A. I don't know the breakdown, but I know a substantial number of people do quit on their own.

Q. Do you agree that a person's motivation to quit is a major factor in whether or not they're going to succeed?

A. I would rephrase it. A person's commitment to want to quit is a major factor.

Q. Would you agree, doctor, that the issue of causation of disease is a matter of judgment?

A. No.

Q. Are you aware that the '64 Surgeon General's report said that it was?

A. That was a long time ago, and --

Q. Do you think -- I'm sorry, I didn't mean to interrupt.

A. There comes a point in studying the potency of a risk factor in disease causation where it's not a matter of judgment anymore; it's a matter of an overwhelming evidence and proof. I would say there's no judgment in determining whether cigarettes cause lung -- lung cancer. That's not a matter of judgment.

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Q. Well, the question of causation generally, isn't that a matter of judgment?

A. I don't think there's any question that HIV causes AIDS, and that's not a matter of judgment.

Q. We know the mechanism for which -- by which the virus causes AIDS?

A. Not completely, no.

Q. We do understand that it is a virus that operates in certain ways in the human body that results in the panoply of symptoms that are associated with AIDS, don't we?

A. Yes, but you asked me is a disease causation always a matter of judgment, and I just gave you an example where it's not.

Q. Right. And that's an example that meets the Koch's postulates, isn't it?

A. That's correct. And the postulates are not fully relevant when you're dealing with, as we all know, a latency period between exposure to the cause/risk factor and the onset of the disease. So you need other kind of criterion postulates that we've discussed.

Q. But if you were to attempt to apply

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Koch's postulates, which are met in the case of AIDS, to the case of smoking and disease, those postulates would not be met; isn't that true?

A. No. Not all of them, no.

Q. So you're agreeing with me?

A. I've agreed, and I've pointed out that there is a major difference in criteria -- there is a difference in criteria of definition of causality between infectious diseases and chronic ones, given the matter of latency.

MR. DODDS: Can we take a few-minute break; I'm nearing the end here.

(Recess taken.)

BY MR. DODDS:

Q. Doctor, I just want to make sure that I understand the scope of your testimony. You will not be testifying regarding biostatistics; is that correct?

A. That's correct.

Q. Are there any subjects for testimony that we did not cover today, so far as you're aware?

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A. I believe we've covered all of them.

Q. Do you intend to conduct any further work or review any further documents in conjunction with your testimony at trial?

A. Not specifically related to my testimony at trial, but I'm always updating my files and literature about the historic aspects of cigarettes, and I may be rewriting my cigarette book. And so I'm constantly gathering new information.

Q. But other than what you ordinarily do in the course of your work, you will not be undertaking any further study or literature review to prepare yourself for testimony?

A. Not specifically for testimony, no.

Q. Insofar as you know, you have not been asked to carry out any further work or study to prepare yourself for testimony; is that right?

A. That's correct.

MR. DODDS: I have no further questions.

MR. HRANITZKY: I have a few questions.

EXAMINATION BY
MR. HRANITZKY:

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Q. Dr. Whelan, my name is Dennis Hranitzky, I represent The Council for Tobacco Research. And to speed things along, I'm going to use CTR to refer to both the Tobacco Industry Research and the Council for Tobacco Research.

Dr. Whelan, I have a tendency to talk quickly sometimes, so if there's any question I ask you that you don't understand, please ask me to repeat it.

You testified a little earlier about the frank statement, and you offered some opinions about the frank statement to cigarette smokers, and I want to come back to your opinions about that document.

But aside from the opinions you've offered earlier today regarding the frank statement to cigarette smokers, do you intend to offer any other opinions regarding the Council for Tobacco Research at the trial in this case?

A. No.

MR. HRANITZKY: I would like to ask the reporter to mark this as Defendant's Exhibit

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14.

(Defendant's Exhibit 14, for identification, frank statement.)

Q. Dr. Whelan, do you recognize this document?

A. Yes.

Q. This is a frank statement to cigarette smokers to which you referred earlier in your testimony; is that correct?

A. Yes.

Q. Is it an accurate characterization of your earlier testimony that the tobacco industry omitted reference to prominent epidemiological studies linking smoking to lung cancer in the frank statement?

A. I said more specifically the frank statement did not put in context the results of the major studies and the consensus of the scientific community -- or, I'm sorry, it was in 1954.

The dialogue of prevailing views of 1954 were not reflected in this.

Q. So it's not your testimony that the industry omitted reference to prominent

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epidemiological studies linking smoking to lung cancer in the frank statement?

A. Well, the frank statement certainly did not summarize the Doll and Hill and the Wynder & Graham studies to make it available to people reading this, no.

Q. But it did not omit reference to --

A. No, that was the strawman that sets this up. Obviously there was reference to it. That's what prompted the frank statement.

Q. Dr. Whelan, I would like to ask you to read the first two paragraphs of this frank statement.

A. "Recent reports on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings. Although --"

Q. Dr. Whelan, I would like to ask you to read verbatim from the document.

A. "Recent reports on experiments with mice have given wide publicity to a theory that cigarette smoking is in some way linked with lung cancer in human beings.

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"Although conducted by doctors of professional standing, these experiments are not regarded as conclusive in the field of cancer research. However, we do not believe that any serious medical research, even though its results are inconclusive, should be disregarded or lightly dismissed."

Q. Okay, Dr. Whelan. In fact, the frank statement refers to research that predated its release, suggesting a link between smoking and lung cancer as serious medical research not to be disregarded or lightly dismissed; isn't that correct?

A. The paragraphs I just referred -- I just read refer to rodents. And this type of information was available back in 1938. This was dated 1954.

Q. Dr. Whelan, apart from the testimony that you offered earlier in your deposition to the effect that the cigarette -- or the tobacco industry did not place in context research that had been conducted prior to 1954 demonstrating a link between smoking and lung cancer in humans, is there any other testimony

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pertaining to the frank statement to cigarette smokers that you intend to offer at the trial in this case?

A. My overall testimony will be that this was a dishonest statement; that it was not a frank statement. A frank statement would have said, from the tobacco industry's point of view, a frank statement could have said we are aware of emerging medical literature in humans as well as animals linking smoking and lung cancer; we take this very seriously. We will herewith summarize the conclusions of that research to date, and then go on from there. But this did not give us a frank statement of what was available.

Q. Okay, Dr. Whelan. Apart from what you have testified up to now today in your deposition, what else in the frank statements to cigarette smokers, if anything, would you characterize as a misrepresentation?

A. Shall we go over it point by point? The medical research of recent years indicates many possible causes of lung cancer. Recent years, being the previous four years. I would

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say that was false.

There is no agreement among authorities regarding what the cause of lung cancer is.

I would disagree with the way that is phrased. There are many leading authorities that feel that this is -- that this data is sufficient to trigger smokers to reevaluate carefully whether they want to take this risk now, even with this preliminary data. 3 --

Q. So, Dr. Whelan, is it your testimony that in January of 1954 --

MR. HOAG: Excuse me. She was finishing -- you can ask her whatever you want, but she was still finishing that answer. She was on No. 3 now.

Q. Okay, Dr. Whelan. I apologize. If you hadn't finished your remarks pertaining to paragraph numbered 2, then please finish those remarks.

A. You asked me if there's any -- you asked me if I would testify to anything else that was wrong that I disagreed with and found dishonest about this, and I was going down it

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point by point.

MR. HOAG: And you can.

A. I disagreed with 1.

MR. HOAG: She can continue her answer?

A. There was no agreement among the authorities. I think that's a misrepresentation of the reality.

3, there is no proof that cigarette smoking is one of the causes.

That is absolutely a misleading statement, because you don't define what proof is. What would be proof to the tobacco industry? There is considerable evidence now that cigarette smoking is one of the causes would be the true frank statement.

That statistics purporting to link cigarette smoking with the disease could apply with equal force to any one of the many other aspects of modern life. And that is absolutely false.

There is no evidence -- there are no prospective studies about air pollution or whatever else modern life is a euphemism for. That was false.

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We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business.

I wish that were true.

We believe the products we make are not injurious to health.

These are all just platitudes, so I just object in principle to them, because by 20/20 hindsight, if nothing else.

I object to all four statements that distinguished authorities are allegedly making.

Q. Dr. Whelan, I want to make sure that I haven't cut you off before you've completed your answer.

A. Thank you.

Q. Just for the sake of clarity, is it your testimony that in January of 1954 there was an agreement among authorities regarding the cause of lung cancer?

A. No, I'm not stating that. But I said the way it's phrased is dishonest. It would be honest and frank to say there is a substantial number of authorities are now

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seriously considering cigarette smoking as a major cause of lung cancer. It is misleading. There is no agreement.

Well, what is agreement?

My objection to this, my accusation of this as being the day the industry became dishonest is based on the fact that this, described as a frank statement to cigarette smokers, is the opposite of frank. It is completely distorting the state of knowledge in January 1954.

Q. So it's your testimony that the statement, "There is no agreement among the authorities regarding what the cause of lung cancer is," is a complete distortion?

A. It's a half truth.

Q. Moving down to the paragraph close to the bottom of the first column: "We accept an interest in people's health as a basic responsibility, paramount to every other consideration in our business."

Are you aware of any evidence that, in January of 1954, the members of the Tobacco Industry Research Committee in fact did not

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accept an interest in people's health as a basic responsibility, paramount to every other consideration in their business?

A. Yes, I am aware of such evidence.

Q. And could you state it?

A. The evidence is the frank statement, because it's not frank. And therefore it shows a disregard for an interest in public health.

If it were a frank statement, it would have explained the state of knowledge with all its ambiguities and all its lack of certainty. And since it did not do that, this advertisement disguised as a frank statement to me manifests a lack of any consideration to human health.

Q. With respect to the paragraph immediately below that: "We believe the products we make are not injurious to health."

Are you aware of any evidence that in fact members of the Tobacco Industry Research Committee, in January of 1954, in fact did believe the products they made were injurious to health?

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A. Obviously the "we believe," people can believe whatever they want. It doesn't necessarily make it true.

It's a platitude; it means nothing.

Q. Are you aware of any evidence that that statement was false?

A. I do not know these individuals, so I can't say one way or the other.

MR. HRANITZKY: I have nothing further.

EXAMINATION BY
MR. CHUMBLEY:

Q. Dr. Whelan, my name is Doug Chumbley and I represent RJ Reynolds Tobacco Company.

At the conclusion of Mr. Dodds' questioning, he asked you if you were going to offer at trial any opinions regarding biostatistics, and you said no; correct?

A. Correct.

Q. That would hold true also for any opinions that concerned statistics of any kind; is that correct?

A. No, that's not correct. I took it to mean am I going to be getting into biostatistical methodology and models. I mean

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obviously epidemiology, any epidemiological assertion will involve some aspect of biostatistics. It's based on biostatistics. But I'm not getting into the --

Q. So your opinions regarding statistics and biostatistics would be relevant only insofar as you're going to offer opinions concerning the consensus of the worldwide medical and scientific community?

A. At a given time.

Q. At a given time?

A. Yes.

Q. And that would be the extent to which your testimony would concern biostatistics or statistics?

A. To the extent I understand your question, the answer is yes.

Q. To what extent don't you understand my question?

MR. HOAG: I object to that question because it's impossible to answer. Unless you can answer it. To what extent do you not understand his question?

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Q. Well, how do you understand my question?

A. I understand you're asking me if I'm going into -- if I plan to go into any detail about biostatistics, modeling theories, the specifics about bell curves and the statistical significance in standard deviations and details of that sort. My answer is no.

But if you want to ask me, if someone asks me what percentage of cigarette smokers are likely to get lung cancer, I would answer that, and that's based on a biostatistical observation; it's about 10 percent. So I would not feel that I would be misrepresenting myself if I proceeded to answer a question like that based on biostatistics.

Q. Let's go back to your discussion of the consensus of the worldwide medical and scientific community that was discussed with Mr. Dodds fairly early on in this morning's deposition.

A. Yes.

Q. And you were talking about -- I'm

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looking at your disclosure statement which I believe has been marked as Exhibit 2.

A. Yes.

Q. You talk about the worldwide consensus of the medical scientific community in that smoking causes disease, including lung cancer, and we discussed lung cancer; is that correct?

A. That's correct.

Q. And you believe that that consensus, as you understand the word, was reached in 1957?

A. Not necessarily. I said there was a consensus meeting then. I don't know that the consensus occurred then. Perhaps it was somewhat before that.

Q. Later?

A. No. I would say it would be the first consensus meeting; the first official grouping of people saying --

Q. No later than 1957?

A. The first consensus on lung cancer.

Q. If you look at the disclosure statement, after lung cancer we have a

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category called "other cancers."

A. Yes.

Q. Do you remember reading that?

A. Yes.

Q. What other cancers are you going to testify to at trial with regard to the worldwide consensus?

A. In the years following the Surgeon General's report, it became clear that cigarette smoking increased the probability, indeed it became a risk factor for a number of sites of cancer, including cancer of the bladder, esophagus, oral cavity, to some degree the stomach, the pancreas.

Q. Any other cancers?

A. Later on it became well understood that cigarette smoking is a significant risk factor for cancer of the cervix.

And most recently we now understand that cigarette smoking is a designated risk factor, or is, as the National Cancer Institute says, colon cancer is a cigarette-related cancer. So that these particular associations, while not available

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at the time of the Surgeon General's report in any substantial way, became apparent over the course of the next 20, 25 years.

Q. With regard to these other cancers that you've described: Bladder, esophagus, oral cavity -- I can't read my own writing -- pancreas, stomach, cervix and colon, you used the word "risk factor."

Your disclosure uses the word "cause."

Are we talking about the same semantic difference?

A. As I mentioned, I think there comes a -- there does come a point, in looking at a risk factor, that the evidence is so overwhelming and the contribution to the disease is so substantial that it becomes a cause.

Q. I understand. Have we reached that point with cancer of the bladder, in your opinion?

A. Cancer of the bladder? I don't know how to answer that. If I were giving a speech to a layman's group this evening, I would call all of those -- yes, I would call it a cause.

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Q. When did we reach that point in time? When was the consensus, in your opinion, of the worldwide medical or scientific community that smoking, in your words, causes bladder cancer; when did that occur?

A. I know that the scientists were specifically involved in that, and I believe that that evidence was pretty much in by -- let's see -- by the early 1980s, if not before.

Q. Tell me what specifically, doctor, you're relying upon to reach the opinion that the worldwide consensus was that smoking causes bladder cancer occurred in the early 1980s?

A. That's my guess. As I said, I knew some of the researchers, because they were at the Harvard School of Public Health, who were trying to look at the teasing out the effect of coffee, caffeine, and cigarettes on bladder cancer. And as I remember that, that occurred in the early 1980s.

Now, when the consensus was reached on

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the specific forms of cancer that I delineated there, that's the kind of thing I would have to look up in the Surgeon General's report, the position during the 1980s, that looked at cigarettes' contribution to all forms of cancer. And that would be a consensus report there.

I'm afraid I can't tell you the year on that right now. It's probably the late 1980s.

Q. So you believe that in your opinion one of the Surgeon General's reports in the late 1980s is your basis for opining that the consensus of the worldwide medical and scientific community had been reached on bladder cancer --

A. Yes.

Q. -- esophageal cancer --

A. Yes.

Q. -- oral cavity cancer --

A. Yes.

Q. -- pancreas cancer --

A. Yes.

Q. -- stomach cancer --

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A. Yes.

Q. -- cancer of the cervix?

A. I would hold off on cancer of the cervix and cancers of the colon. I think that would probably come a number of years later.

Specifically on colon cancer, I believe that the Journal of National Cancer Institute issued a statement on colon cancer as a cigarette-related cancer in approximately 1992.

Q. And when we talk about the consensus with regard to all of those other kinds of cancers, we're talking about a consensus that the risk factor had reached such a level that in your opinion it equated with causation?

A. No, I didn't quite say that. I'm saying that the data linking cigarettes with an increased risk of these cancers reached a consensus level in that time frame that I gave you, as represented in review articles that brought together 10, 15, 50 studies that said look at all of these, they're all pointing in the same direction, published in the Journal

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of the American Cancer Institute.

In terms of making it a cause, I'm sorry we're back to semantics on that paragraph, if you were to call the head of the National Cancer Institute right now and said you were a reporter with the Associated Press and you wanted to know is cigarette smoking a cause of bladder cancer, I would suggest to you that he would answer yes, knowing in his mind it was a risk factor, a major risk factor.

As a matter of fact, the most preventable risk factor, other than occupational exposure, that we know.

Q. You would say the same thing for esophageal cancer?

A. Yes.

Q. Cancer of the oral cavity?

A. Oh, yes. Yes.

Q. Cancer of the pancreas?

A. Yes.

Q. Cancer of the stomach?

A. No, he wouldn't say the same thing for cancer of the stomach. He would give you

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a more detailed answer. That there is difference worldwide in the contribution of smoking to stomach cancer seems to be very, very prominent in Japan as a cause. Here it's more of a lower-level risk factor rather than a definitive cause.

Regarding colon cancer, he would say that that is a risk factor, one that we now know is an irreversible risk factor, after ten years of smoking. But it would not be so much a cause.

Now, the distinction to be made here is that unlike something like lung cancer, which is a very rare disease, relatively speaking, in the absence of smoking, colon cancer is not a rare disease. It's the third -- now it's the third leading cause of cancer death. And it occurs substantially in nonsmokers as well as smokers. So I would use a different terminology there.

I would call colon cancer a cigarette-related cancer. I would call cigarette smoking a risk factor for colon cancer. But I really wouldn't go as high as

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cause.

Q. The one document that you can tell me today that you are basing your opinion on with regard to the consensus of the worldwide medical and scientific communities with regard to these other cancers is the Surgeon General's report?

A. That's one of them.

Q. What else?

A. I would go in -- if I had the Index Medicus here, I would point out, let's say, in the early and mid-1980s, a number of review articles on bladder cancer and cigarettes, most of which was written by this man, Philip Cole, who wrote the preface on my book, and I would show you that these literature reviews, which went over the conclusions of X Y number of studies, said recent literature, now, you know, it points to the conclusion that bladder cancer and cigarette smoking are causally linked.

Q. But you can't, as you sit here today, doctor, give me the title or the author of any of those studies?

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A. No. I mean I don't walk around with the Index Medicus on my head. But I know it's there and I could find it. It's in the literature. As a matter of fact, it's probably summarized in my book, "Preventing Cancer," in the next edition.

Q. The next edition?

A. Yes, the edition that followed this. It was reprinted as a new book about two years ago.

MR. HOAG: When you say "this," you're referring to what? I don't know it was marked as an exhibit, but it's "Preventing Cancer, What You Can Do To Cut Your Risks By Up To 50 Percent"?

THE WITNESS: Yes.

MR. HOAG: It was discussed by Mr. Dodds earlier today?

THE WITNESS: Yes.

Q. There was a more recent version of that?

A. There was a more recent version, updated version, I think it was in 1995, approximately.

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Q. In questioning by Mr. Dodds, you discussed the consensus of the worldwide medical and scientific community with regard to COPD, and also with heart disease.

Do you remember that?

A. Yes.

Q. If you look at the disclosure statement, after heart disease was cardiovascular disease. What, in your mind, is the difference?

A. Between?

Q. Heart disease and cardiovascular disease.

A. You know, in our booklets on the subject of CHD, the physicians involved in writing that section do make a distinction, and I really can't tell you whether, you know, the difference between the causation of longtime chronic -- longtime cardiac failure versus sudden heart attack, I really can't determine that. But I know there certainly is a distinction.

Q. There is a distinction between heart disease and cardiovascular disease, but you

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can't tell me what that is?

A. No, I can't.

Q. You told Mr. Dodds that in your opinion there was a consensus of the worldwide medical and scientific community that smoking causes heart disease and that occurred, if my notes are correct, in the early 1960s?

A. That there was a consensus. It doesn't, I would say more like the mid-1960s.

Q. Mid-1960s?

A. Yes.

Q. When in your opinion was there a consensus of the worldwide medical and scientific community that smoking caused cardiovascular disease?

A. I don't know,.

Q. So you're not going to offer any opinions on that at trial?

MR. HOAG: You mean as to when? Is that what your question specifically is requesting?

MR. CHUMBLEY: Yes, as to when.

A. I'm just blanking on that right now. Although we do have booklets on this subject and I would have to refresh my memory on it.

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Q. But you can't tell me today when that occurred?

A. No.

Q. Can you tell me today if it's occurred? In other words, is there a worldwide consensus of the medical and scientific community that smoking causes cardiovascular disease?

A. I'm rustling here with the definitions that we're looking at. There was a worldwide consensus that cigarette smoking is one of the three preventable controllable causes of heart disease. Now, I am not breaking them down by the correct categories.

Q. Well, cardiovascular is in your disclosure, and that's why I'm asking questions about it.

A. Yes.

Q. Is there in your opinion a worldwide consensus of the medical scientific community that smoking causes cardiovascular disease?

A. I would like to stick with the terminology on heart disease, that there is a worldwide consensus that smoking is one of the

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controllable and preventable causes of heart disease, generically speaking.

Q. So can I draw a line from cardiovascular disease in your disclosure?

A. Yes. You can keep it generic on heart disease.

Q. There's also a category in your disclosure called quote, "other diseases," which didn't get much discussion with Mr. Dodds. What other diseases are you including in that, doctor?

MR. CHUMBLEY: No offence, Ned.

A. I think that the answer can be found in this book here that we edited, which goes through all of the consequences of cigarette smoking and what the causal links are.

When you say what diseases, there are a myriad of them. Whether we're talking here about osteoporosis and bone losses related to cigarette smoking, that's a morbid condition.

Or we're talking about pregnancy loss. Or we're talking about blindness, as a result of macular degeneration.

When I mean other diseases, there is a

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full spectrum of diseases, all of which are described in this book.

MR. HOAG: You need to identify the book, for the record?

A. The book is "What The Warning Label Doesn't Tell You."

Q. I'm concerned, doctor -- and I appreciate your answer -- but I'm concerned about what "other diseases" you intend to get on the witness stand and tell the jury that there is a worldwide consensus of the medical and scientific community that these "other diseases" are caused by smoking.

A. Okay.

MR. HOAG: The book that you edited, if you needed to refresh your recollection, you can use it.

A. I don't know what to say, other than the fact that this book represents the medical consensus of all the health consequences. In other words, all the diseases that are causally linked to cigarettes, all the diseases for which cigarettes are a risk factor, they are all in this book. There are

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many of them.

Now, I am not an expert in gastrointestinal disease. But according to my scientists who wrote this chapter, there are all kinds of increased risk of Crohn's disease, duodenal ulcers and all sorts of other things; it's all right here.

Am I testifying on that?

Q. That's my question.

A. If someone asks me what's in this book and I have it and I could read it to them.

Q. Otherwise you're not qualified to testify on it?

A. I am qualified, because I'm the editor of this book, and I commissioned and have my name -- I am responsible for this book. So am I qualified to read and discuss its contents? I think so.

Q. Can you tell me as you sit here today, for example, doctor, when the consensus of the worldwide medical and scientific community was reached that smoking causes duodenal ulcers; when did that occur?

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A. I do not know.

Q. Do you know if that consensus has even occurred today?

A. Yes, that I do know. Because that was the ground -- that was the requirement for getting in this book.

Q. And is the basis of your opinion that there is a consensus of the worldwide medical and scientific community that smoking causes duodenal ulcers; the basis for your opinion that there is such a consensus the fact that it's in your book?

A. No. As a matter of fact, it is in my book because it was peer-reviewed by a panel of distinguished physicians and scientists who agreed that it met the definition of being a known health consequence of smoking. It's nothing theoretical, it's nothing proposed. There was substantial, enough evidence in the medical literature that it be listed on the complete assessment of the health consequences of smoking.

We have, as an appendage to this book, which I am able to discuss, a chart listing

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every disease that's mentioned in this book, and how we would grade the level of consensus on that subject. We have that as a document, which I would be able to discuss.

Q. That's in the book?

A. It is not in the book. We took it out at the last moment. But we have the chart.

If someone were to ask that question -- there are also levels of consensus and levels of -- the degree of information.

For example, the number of articles that have been written about lung cancer causally linked with cigarette smoking is substantially larger than those linking osteoporosis, for example, with smoking. But that doesn't mean that one is less secure as a consensus. It's just that they got to a point where, you know, why do 7,000 studies when you have 70 that all point in the same direction.

Q. That chart was taken out of the book why?

A. We write our books for lay people, and we thought that might overwhelm them, to

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have a chart of that sort.

Q. You've mentioned that book was peer-reviewed?

A. Oh, yes.

Q. By whom?

A. It was peer-reviewed by the people listed here.

MR. HOAG: In the acknowledgment section.

A. In the acknowledgments. And the chapters themselves were written by all of these physicians whose names are listed here.

Q. I understand. The chapters were written by somebody other than you?

A. Right.

Q. Correct?

A. That is correct.

Q. And then they were peer-reviewed by somebody different than the persons that wrote the chapters?

A. Yes. Like, for example, most peer-reviewed journals have two or three reviewers. We have here approximately 30 reviewers.

Q. But do you count amongst the peer

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reviewers the authors of the chapters?

A. No.

Q. You mentioned, in response to Mr. Dodds' questioning about your opinions concerning the tobacco companies aggressively pursuing litigation and other means against any individual or institution, as part of your discussion with Mr. Dodds on that, you mentioned the fact that you have heard and had discussions with friends of yours who are editors of magazines who have told you that, I believe this is what you said, that the tobacco companies somehow threatened to pull advertising money if they wrote copy that talked about the health consequences of smoking; is that correct?

A. Yes, but I actually said it much more broadly. I said that the editors that I've spoken with have told me that advertisers of any kind will not tolerate negative comments about the product.

Q. So that's not something that's unique to the tobacco industries; is that what you're saying?

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A. Excuse me?

Q. That's not something that's unique to the tobacco industry?

A. No. That particular aspect is not unique. But it's one thing to have articles on, criticizing Gerber Baby Food omitted information from a baby magazine, as opposed to articles talking about lung cancer and emphysema cut out. The consequences are universes apart, of the spiking, if you will, of the different types of articles.

Q. Tell me what editors you're referring to that you've had these discussions with?

A. One particular person is the editor of American Baby magazine, and her name is Judith Notle, and she has been a magazine editor for many years. And she is also the editor of Weight Watchers magazine.

She told me of many stories in her experience of copy actually being edited.

I have talked with editors at Harper's Bazaar and Vogue.

I have had very --

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Q. What are their names?

A. The editor at Vogue, her name is Jane Ogle, O-G-L-E.

And she has told me specifically of examples, involving me on occasion, where the editor has killed or edited stories specifically to please the cigarette companies. And I've written up those particular examples before.

Q. Who is the editor of Harper's Bazaar that you're referring to?

A. The one who made the cut? The man who cut my articles?

Q. You said American Baby, Judith Nolte; Vogue, Jane Ogle.

A. Jane Ogle is editor at both Harper's Bazaar -- she was an editor of both.

Q. Who, Jane Ogle?

A. Yes. And the editor of Harper's Bazaar, who actually demanded that my articles would remove the references to smoking, his first name is Tony, and his last name is something like Mazerrelli. And he was editor of Harper's Bazaar for many years.

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In addition to that, I've had extensive discussions with Grace Mirabella, who was the founding editor of Mirabelle Magazine, and who was the editor of Vogue for years and years and years. And we have had candid and in-depth discussions about pressure from cigarette companies as to covering the dangers of smoking.

Q. Have you talked to her, or any of these other editors, about dealings with other kinds of advertisers other than tobacco advertisers?

A. Yes.

Q. Is it basically the same thing?

A. Yes, the same type of pressure.

Q. You mentioned, and I can't remember what it was in reference to -- let me just check my notes -- okay. This is also with regard to other means that you claim the tobacco companies have prevented the truth from coming out, as you put it.

You talked about your personal experiences at the Greenbrier and Good Morning America; do you remember that?

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A. Yes, I do.

Q. Any other personal experiences other than those, I think you mentioned three; the Greenbrier incident in 1990, the Good Morning America in 1977, and the Pineapple Association of America in 1980? Any other personal experiences other than those three?

A. I've had many experiences where I've had influence on me from tobacco-related sources not to speak.

Q. But these are the only three you can remember today specifically?

A. I've had corporate funders tell me that my comments on tobacco were upsetting tobacco companies, and that they were leaning on them. For example, Ciba Geigy is a company that makes agricultural chemicals, and they were pressured by tobacco companies to try to quiet me down or else they said they wouldn't buy their pesticide anymore. That type of thing is very common.

There are many examples of that.

Q. And you did actually mention one of those, and that had to do with a letter from,

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I think you said RJ Reynolds to Dow Chemical?

A. Yes, that's correct.

Q. Do you have a copy of that letter?

A. I would give anything for a copy of that letter. No, he wouldn't give me the copy. This is the man, this is the chairman of Dow.

Q. And his name was?

A. Paul Orrefice.

Q. Last name again?

A. O-R-R-E-F-I-C-E.

Q. What year was that again?

A. I would say that might have been 1984, '85.

Q. And you're sure it was from RJ Reynolds?

A. That's what he told me. He said that he had been -- he had a letter from his counterpart and that they were very unhappy with me, and the American Council on Science and Health, and that they were not going to -- they were playing hardball, and they were not going to buy from -- they were not going to do business with those who funded their enemies.

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Q. And what was the name of the counterpart at RJ Reynolds?

A. That I don't know. Mr. Orrefice told me it was the chairman. A chairman-to-chairman letter.

Q. You also mentioned, in direct-examination, I think you called it a full-page ad that was taken out by RJ Reynolds which had misrepresented the results of a study?

A. Correct.

Q. What study was that again? I couldn't hear you down at this end of the table.

A. Yes. It was the MRFIT study. I believe that stands for Multiple Risk Factor Intervention Trial.

Q. MRFIT?

A. M R, and then F I T. They call it MRFIT. Multiple Risk Factor Intervention Trial. It's a federally funded --

Q. It's an acronym then?

A. It's an acronym, yes.

Q. I couldn't figure out whether it was

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an acronym or a name of a person.

A. No, it's an acronym.

Q. When did this ad appear?

A. The ad appeared in the mid-1980s. I wrote extensively about the ad. I critiqued the ad. I complained to the Federal Trade Commission about the ad.

Q. Did they take any action?

A. They did. They had meetings and evaluated it, and years went by. Eventually they did admonish RJ Reynolds, as I recall, but they did not require corrective action, as we had requested.

Q. Do you know what the circulation of that ad was?

A. I have no idea.

Q. Where did you see it?

A. I think I saw it in Newsweek.

Q. One of the things you mentioned in the course of your answers to Mr. Dodds -- and I just want to clarify -- are you appearing here today -- and this arises out of some confusion that I have as to whether you're appearing on behalf of Elizabeth Whelan or

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whether you're appearing on behalf of the American Council for Science and Health, because you made a statement earlier that your opinions are your company's opinions.

Which one is it? Are these your opinions or are these the opinions for the American Council of Science and Health, for which you are a spokesperson?

A. I'm here as an individual. And my opinions are my own. However, I pointed out that on these vast topics that I address, that my opinions are based on the reviewed, peer-reviewed conclusions of my scientific panel.

However, there are some things that were said here today which are my views alone. The one I specifically recall is that we discussed a cigarette license. I didn't even recall that I had even written that up, but that is something that my directors would not agree with.

But I can't think of any other example here today of any other topic that we've addressed that was not -- that my conclusions

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and views are directly derived from the panel's, my scientific panel's review and conclusions.

Q. So your opinions that you expressed here today with regard to the government mandated warnings, for example, are also the opinions of the directors of your organization?

A. No, I cannot recall them ever having -- them ever signing off on that one way or the other.

Q. So that's another one that's your opinion alone?

A. Technically, yes. Though they have never objected to that, while they have objected to the license.

Q. Do they even know that you hold that personal opinion?

A. Oh, yes. They read the New York Times, the Wall Street Journal.

Q. So the directors know that you hold the opinion that the federally mandated warning should be stopped?

A. Yes. All of the directors and the

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300 physicians and scientists associated with the American Council receive everything I write and have an opportunity to protest and disassociate themselves, and no one ever has.

Q. They haven't disassociated themselves from your opinion that the warnings ought to be stopped?

A. No.

Q. Any other opinions that you've offered here today that are your opinions personally as opposed to the opinions that have received the blessing of the directors of the American Council of Science and Health?

A. Possibly there are. I did the historic review -- I made a statement that I thought that the first consensus was reached on lung cancer and smoking in 1957. That's in my books, but that was never peer-reviewed. The historical material, they have not been involved in so much.

Q. Who are the current directors of the American Council for Science and Health? How many are there, first of all?

A. There are approximately fourteen.

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And their names are listed on all of our booklets and our pamphlets and our letterhead, and I would be happy to provide that to you.

Q. Doctor, I was interested in your testimony earlier today when Mr. Dodds was asking you about whether or not any of your opinions were changed if a jury were to reach a different decision. Do you recall that?

A. I don't recall it in that context, no.

Q. What context do you recall it in?

A. I recall saying that if a jury made a decision that the current wording of the warning label was sufficient to cover the tobacco companies and disclose all risks, that they decided that, then I would have to go with the jury's decision.

Q. You were a witness in the case of Karbiwnyk versus RJ Reynolds Tobacco Company; is that correct?

A. I gave a videoed deposition.

Q. Right. And in fact Mr. Dodds asked you some questions from your testimony in Karbiwnyk; correct?

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A. I believe so, yes, mm-hmm.

Q. Are you aware that your videotaped deposition was shown to the jury in that case?

A. I have been so told.

Q. Have you also been so told that the jury reached a verdict that said there was no failure to warn on behalf of RJ Reynolds?

A. I am familiar with the verdict.

Q. You're familiar with the fact that they specifically found no failure to warn?

A. That's right.

Q. That doesn't change your opinions?

A. No, not at all.

Q. Why not?

A. Because the warning label now is mandated, and the impression, and the argument of the tobacco industry has been that they are not required to go further because they have been preempted; that a government warning preempts them from giving any fuller disclosure.

What I'm arguing is that if there had not been that government involvement, the warning label as it exists now -- not that the

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tobacco industry would ever put that silly warning label on because it's so incomplete -- but if it were put on, it would be deemed completely inappropriate and insufficient as there have been cases involving pharmaceutical companies who have been far less blatantly inadequate.

I used the example in my writing of the Ortho Pharmaceutical warning about cerebral vascular accidents associated with oral contraceptives associated with not full disclosure because the word "stroke" was not used.

And so the fact that the Karbiwnyk jury ruled the way it was, I don't see relevant to my argument.

Q. We talked earlier about whether or not it's your intention to offer any opinions at trial concerning biostatistics and statistics, and you stated no, it's not your intention to get into the nuts and bolts of it, if I understood your answer correctly. Is that right?

A. That's correct.

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Q. Do you intend to give any testimony at trial with regard to attributable risk?

A. Not that I'm aware of, no.

MR. CHUMBLEY: That's all I have, thank you.

MR. DODDS: I had a few follow-up questions based on some questions from Mr. Chumbley.

CONTINUED EXAMINATION

BY MR. DODDS:

Q. You mentioned that if someone, a reporter called up the head of the National Cancer Institute and asked about whether or not -- I forget the form of cancer that you used as an example, perhaps it was a bladder cancer -- you said that the head of the National Cancer Institute might answer that it was a cause because he knew it was for popular consumption.

Am I stating your testimony accurately?

A. Yes, that is correct.

Q. If he had said that it was a risk factor, would he be inaccurate in doing so?

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A. No.

Q. If he said that smoking was a risk factor for lung cancer, would he be inaccurate in doing so?

A. He would be -- it would depend in the context of why he was answering this question. I'm afraid I would have to give that distinction.

Again, if you were participating in a Harvard School of Public Health seminar and talking about -- let's sit down and talk for an hour about the risk factors, the risks associated with smoking, what's the top risk factor?

But if you were a reporter calling him and talking about a prevention program or something, "risk factor" would sound like a euphemism in lay discussion. And that's why I object to it.

Q. A euphemism for what?

MR. HOAG: Let her finish.

Q. Go ahead, I'm sorry.

A. A euphemism for cause. That those who were trying to deny cause will hide behind

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the euphemism "risk factor" as if it would somehow distance themselves from reality; that those people who smoke cigarettes have a higher frequency of the disease in question. That's what matters.

Q. Well, if the public understands the words "risk factor" to mean cause, how are they being misled by the use of the words "risk factor"?

A. Because I don't think they do understand it that way. Risk factor to them could mean some hypothetical: Well, maybe, you know, it's under consideration, and there's a lot of research going on, we'll let you know if it ever is a cause, and that's not the way it is.

Q. So if the head of the National Cancer Institute uses the words "risk factor," it's semantic, but when the tobacco company uses those words, it's fraud?

MR. HOAG: I object to the form of the question; mischaracterizes her testimony.

A. The Tobacco Institute, when it uses the term "risk factor," never defines what

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they mean by it, and they use it as a, I believe, a bit of a sham to avoid the word "cause."

Q. Leaving aside what's in the heart of the person who is using the words, if the words are the same it would have the same effect, misleading or not, on the listener; isn't that true?

A. No, it doesn't. Obviously it does not. And when we hear the industry refer to lung cancer and cigarettes -- cigarettes is a risk factor for cancer, it makes it sound like there are a million other ones, too, and this is caught up there in the mix, and this is relatively unimportant. It's ridiculous. It's the No. 1 preventable life-style factor for lung cancer. And "risk factor" is fine for an academic seminar, but I object to its use in educating people as to prevention and introspection as to their own life-style.

Q. We had a discussion about some of the other cancers that you might testify to. You mentioned esophageal cancer; is that right?

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A. That's correct.

Q. You believe that's associated with smoking?

A. Well, esophageal cancer is really a unique cancer, because it's the one that is associated with a combination of smoking and alcohol consumption. I make a distinction there. Everything is complex; you can't have simple -- you don't have simple answers.

As far as I'm concerned, cigarette smoking alone is not a major cause of esophageal cancer.

The cause is the one of synergism of those two: Alcohol and cigarettes.

Q. Would you say the same is true with respect to laryngeal cancer?

A. No. That is not as strong there. It's esophageal cancer that is -- it is definitely a synergism but it's not as strong.

Looking at cases of esophageal cancer, from my review of the literature, which hasn't been that recent, that it's relatively rare that you don't find both factors, while other forms of oral cancer and throat cancer, you

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can have just the cigarette smoking.

Q. Do you believe, then, doctor, that smoking is associated with laryngeal cancer?

A. Yes.

Q. And with cancer of the pharynx?

A. Yes.

Q. And of the mouth itself?

A. That's what we have in here, yes (indicating).

MR. HOAG: When you say "in here," you need to describe it.

A. This is what we have in our book under smoking, we have it broken down into head and neck cancers, esophageal cancers, oral cancer, nasal cancer, cancer of the salivary ducts. The entire laryngeal cancer as well.

MR. HOAG: The book, you're talking about the "First Comprehensive Guide to the Health Consequences of Smoking"?

THE WITNESS: Yes, I am.

Q. Doctor, I believe you have in the past cited the fact that lung cancer incidence has increased significantly over the course of

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this century as primary evidence of its association with cigarette smoking. Is that true?

A. Not technically. I believe I've limited my comments to lung cancer mortality. Since we don't have a national reporting system, I stick to mortality as increased substantially.

Q. You basically said that as mortality from lung cancer has increased, that parallels the increase over the course of this century in cigarette smoking; is that correct?

A. Parallel with a latency lead, yes.

Q. Can you explain for me why the incidence and mortality from laryngeal cancer, which you say is also associated with smoking, has decreased during that same time frame?

A. No, I cannot. And I'm not familiar with the mortality data on that.

Q. Would the same be true for all of the other cancers that you believe to be associated with smoking, the incidence of mortality which have decreased during the same period of time as the incidence for mortality

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from lung cancer has increased?

A. I'm not prepared to comment on that now. It's rather complex. You're dealing with matters of competing mortality.

For example, you're dealing with, for example, the linkage of cigarette smoking in cervical cancer and perhaps cigarettes and bladder cancer. There are other competing causes of that.

In the case of bladder cancer, we know of occupational exposures that have caused bladder cancer.

So as there are changes, as there are, for example, less exposure to occupational betanaphthyl or whatever chemical in the dye industry, then that would cause a decline in bladder cancer regardless of what cigarette smoking was doing.

Q. Do you believe that's true for each of these cancers?

A. In terms of causes? Well, for example, cigarette smoking is one of the causes of cervical cancer. But there are other known causes of cervical cancer as well.

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And one of them is age for sexual activity versus sexual intercourse. And that has changed.

Venereal diseases are risk factors for cervical cancer. It's more complicated. Unlike lung cancer, when you're dealing with 90 percent of it being linked to smoking.

There are multiple causes for some of the other sites.

MR. DODDS: That's all I have, thank you for your time, doctor.

(Time noted: 4:55 p.m.)

_____

ELIZABETH WHELAN

Subscribed and sworn to before me this _____ day of _____, 1998.

_____

Notary Public

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CERTIFICATE

STATE OF NEW YORK)
: Ss.
COUNTY OF NEW YORK)

I, FRANK BAS, a Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify:

That ELIZABETH WHELAN, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 30th day of January, 1998.

_____

FRANK BAS

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